

Guard Plans

Fixed benefits health insurance

THIS PRODUCT PROVIDES LIMITED BENEFITS

THIS PRODUCT IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE AFFORDABLE CARE ACT (ACA).

This fixed indemnity insurance product provides benefits in a stated amount regardless of actual expenses incurred. Golden Rule Insurance Company is the underwriter of these insurance plans.

Policy Form HPG3-CSTM-GRI and other state variations

United Healthcare

Golden Rule Insurance Co.

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Why choose us?

Strength and experience

UnitedHealthcare provides over 29 million Americans with access to health care.[1] Golden Rule Insurance Company, a UnitedHealthcare company, is the underwriter and administrator of plans featured in this brochure. We have been serving the specific needs of individuals and families buying their own coverage for over 80 years.

Highly rated

Golden Rule Insurance Company is rated "A+" (Superior) by A.M. Best.[2] 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.

Your satisfaction is our goal

We understand the importance of your time and concern for the value of your health care dollars. Our goal for every customer is an insurance plan at a price that fits their needs and budget.

[1] UnitedHealth Group Annual Form 10-K for year ended 12/31/24. [2] As of 3/12/25.
For the latest rating, access ambest.com.

This is an outline only and is not intended to serve as a legal interpretation of benefits. Reasonable effort has been made to have this outline represent the intent of contract language. However, the contract language stands alone and the complete terms of the coverage will be determined by the policy. State specific differences may apply.

Guard plans

Coverage to supplement your health coverage with straightforward cash benefit amounts for the everyday and not-so-everyday health services. Designed to help ease out-of-pocket costs you might experience when getting health care.

What is fixed benefit health indemnity insurance?

"Indemnity" is insurance speak for a plan that pays you[1], or your provider, a specified amount – or "fixed benefit" – for medical services you receive that are covered by the plan. The benefit isn't based on the total amount of your medical bill. There are also limits on how much or how many times this policy will pay on some benefits.

Why is fixed indemnity insurance a good idea?

A fixed indemnity plan is designed to offer supplemental relief of out-of-pocket costs you may have related to covered medical services. The benefit pays a fixed amount, regardless of the actual cost billed or other insurance coverage you may have. This could mean some benefits pay more than the cost of the service or for other services, it may cover just a portion of the cost, but the amount left you owe to the provider will be less.

How does a fixed indemnity insurance plan work?

With this type of plan, there is **no deductible, no coinsurance or even copays**. When you have a covered medical service provided, this plan will pay the benefit amount (shown on the following pages) to your in-network provider, or to you. This payment, along with the discounts on services you receive using an in-network provider, helps to reduce your overall out-of-pocket responsibility.

Our Guard plans offer hospital and doctor benefits

The Guard plans available in this brochure have:

- Doctor office visits, urgent care visits and prescription drug benefits[2]
- Benefits for hospital stays, emergency room visits, surgical services and ambulance trips
- Unlimited, no-cost virtual health visits (through HealthiestYou by Teladoc® Health) for general non-urgent medical issues
- Flexibility to use any doctor, but discounts for using UnitedHealthcare Choice Plus network providers
- Increase in cash benefits for qualifying services by staying with the plan more than a year

It's also good to know:

- Available for issue ages 18 through 64 in most states
- Renewable until age 65, subject to policy provisions, when premiums are paid
- Increased benefit amounts if you keep the plan for at least 2 years **(see pg 5-6 for details)**

[1]If you assign your policy benefits to a hospital or any other provider of health care services, benefits will be paid to the provider. [2]Prescription drug benefits are not available on Guard 4000 plan.

Save with network discounts

Get nationwide access to quality care and savings

You can use any provider you choose for medical services, but you'll get the most out of your Guard plan benefits when you use the UnitedHealthcare Choice Plus network.[1]

Great reasons to use a UnitedHealthcare Choice Plus network provider:

- You'll get care at pre-negotiated lower rates
- Network providers will file claims on your behalf
- With a large nationwide network, an in-network provider may be nearby

1.8M+ providers[2]

7,000+ hospitals[2]

58% average discount savings[3]

Example savings

Take a look at these sample claims, the network savings, and how it works with the plan.

Treatment (services claimed)	**Actual treatment cost**	**Treatment cost after Choice Plus Network discount**	**Plan benefit** (Guard 5000 plan)	**Total member responsibility using Network provider**	**Total member responsibility using non-network provider**
Office visit (1 visit)	$175	$72	$100	$0 ($28 paid to member)	$75
Outpatient x-ray (2 tests)	$1,090	$238	$100	$138	$990
Outpatient facility (1 day)	$12,031	$2,632	$1,500	$1,132	$10,531
Emergency room (1 visit)	$5,770	$2,400	$500	$1,900	$5,270
Hospital admission & room/board (6 nights, standard stay)	$15,600	$6,425	$5,600	$825	$10,000

These are samples based on actual claims. Amounts have been rounded for simplification. Actual treatment cost and network discounts vary by area. Benefits vary by plan (state variations may apply). These samples are for illustration only, to depict how the plan works.

More on filing a claim

When you present your plan ID card to your in-network provider, they file the claim with us, and we send the benefit payment to them. The provider will apply the payment toward the amount you owe for the service provided. This, in addition to the network discount, helps to reduce your final bill and lowers your total out-of-pocket cost. If the eligible benefit payment is more than the cost of coverage, even after the discount, you will receive the difference mailed to you as a check from us. If you do not use a network provider, you can submit your claim directly to us. Refer to your policy for more information or go to uhcmemberhub.com. (See page 9.)

[1] If you have a major medical plan, you may need to stay with certain networks/providers to get the most coverage out of that plan. [2] UnitedHealth Group Annual Form 10-K for year ended 12/31/23. [3] Based on 2023 E&I Healthcare Econ & Pricing data of UnitedHealthcare Choice Plus network; average across combined in-patient and outpatient services. Savings experience can vary by provider and service.

Hospital and outpatient benefit details

All benefits, including maximums (max) are per person, per calendar year.		Guard 4000	Guard 5000	Guard 6000
Hospital services				
Hospital Admission Benefit - First Inpatient Day[1]	We pay:	$4,000 per day (max 1 day)	$5,000 per day (max 1 day)	$6,000 per day (max 1 day)
Inpatient Hospital Confinement Illness/Injury[1]	Year 1 we pay: Year 2 we pay:[2]	$100 per day (max 31 days) $200 per day (max 31 days)	$100 per day (max 31 days) $200 per day (max 31 days)	$100 per day (max 31 days) $200 per day (max 31 days)
Inpatient Doctor Visit	We pay:	$100 per day (max 1 visit per day)	$100 per day (max 1 visit per day)	$100 per day (max 1 visit per day)
Emergency Room	We pay:	$300 per day (max 3 days)	$500 per day (max 3 days)	$600 per day (max 3 days)
Ambulance (maximum combined trips of any type)		1 trip	1 trip	1 trip
Ground/Water Ambulance	We pay:	$500 per trip	$600 per trip	$600 per trip
Air Ambulance	We pay:	$3,000 per trip	$3,000 per trip	$3,000 per trip
Surgical benefits (represent a range for 7 surgical tiers; **see page 7** for additional details)				
Surgical Procedure	We pay:	$125-$12,500 per day (max 2 days)	$125-$12,500 per day (max 2 days)	$250-$25,000 per day (max 2 days)
Outpatient Facility	We pay:	$1,000 per day (max 2 days)	$1,500 per day (max 2 days)	$2,000 per day (max 2 days)
Outpatient tests (maximum combined of any type)		Not applicable	4 tests	4 tests
Outpatient X-ray		Not covered	$50 per test	$100 per test
Outpatient Diagnostic Tier 1 (Ultrasound, EKG, EEG, Angiogram, Arteriogram, Thallium Stress Test, and Myelogram)	We pay:	Not covered	$250 per test	$500 per test
Outpatient Diagnostic and Imaging Tier 2 (MRI/PET/CAT)	We pay:	Not covered	$500 per test	$500 per test

Benefit availability, amounts, periods, and limitations may vary by state. See State Variations. Benefits are subject to Preexisting Conditions. **See page 11** for details. [1] Includes Observation Unit stays of 24 hours+. [2] This increase in benefits does not apply to Inpatient Hospital Confinement for illness. Benefits for injury increase on the 1st day of the next full calendar year after the plan has been in force more than 6 months. If the plan has not been in force more than 6 months, the benefit increase will begin January 1 following 12 consecutive months of coverage. This increase occurs only once.

Dr. visit and Rx benefit details

All benefit maximums (max) are per person, per calendar year.		Guard 4000	Guard 5000	Guard 6000
Office Visits (maximum Office Visits, any type combined)	Year 1 max: Year 2 max[1]:	4 visits 6 visits	4 visits 6 visits	4 visits 6 visits
Doctor Office Visits	We pay:	$80 per visit	$100 per visit	$120 per visit
Specialist (SP) Office Visits/Urgent Care (UC) Visits	We pay:	$100 per visit	$120 per SP visit $150 per UC visit	$140 per SP visit $200 per UC visit
Office Visits with in-office surgery in lieu of Doctor/Specialist/Urgent Care Visits	We pay:	$200 per visit	$225 per visit	$250 per visit
Therapy Visits				
Chiropractic/Physical/Occupational/ Speech Therapy Visits	We pay:	$25 per visit (max 10 visits)	$35 per visit (max 10 visits)	$50 per visit (max 10 visits)
Rx Drugs (maximum fills, any type combined)	Year 1 max: Year 2 max[1]:	Not applicable Not applicable	10 fills 15 fills	10 fills 15 fills
Name Brand Prescription Drugs	We pay:	Not covered	$40 per fill	$40 per fill
Generic Prescription Drugs	We pay:	Not covered	$10 per fill	$10 per fill

Benefit availability, amounts, periods, and limitations may vary by state. See State Variations. Benefits are subject to Preexisting Conditions. **See page 11** for details. [1]Benefits increase on the 1st day of the next full calendar year after the plan has been in force more than 6 months. If the plan has not been in force more than 6 months, the benefit increase will begin January 1 following 12 consecutive months of coverage. This increase occurs only once.

The policy does not contain comprehensive adult wellness benefits as defined by Wyoming law.

How the surgical tiers are determined

Each plan has a 7-tier surgical schedule based on the relative value unit[1] of the procedure being performed. The amount for the respective tier will be paid each day a covered person requires inpatient or outpatient surgery[2] as prescribed by a doctor. If surgery falls under multiple tiers, we will pay the largest amount and if multiple surgeries are performed in a single day, we will pay one amount for the highest tier procedure.

		Guard 4000	Guard 5000	Guard 6000
Surgical Benefits Surgery Tier examples are for illustrative purposes only. Surgical Benefits are per day, limited to a maximum of 2 days per calendar year.				
Tier 1 Surgeries for major organ/tissue failure transplants payable once per each of the following major organ types per covered person's lifetime: liver, heart, lung, kidney, pancreas, bone marrow, stem cell, or small intestine.	We pay:	$12,500	$12,500	$25,000
Tier 2 Surgeries such as intracranial vessel surgery or removal of esophagus.	We pay:	$5,000	$5,000	$10,000
Tier 3 Surgeries such as endoscopy, partial removal of pancreas or replacement of mitral valve.	We pay:	$2,500	$2,500	$5,000
Tier 4 Surgeries such as lumbar spine fusion, colectomy, or repair of mitral valve.	We pay:	$1,250	$1,250	$2,500
Tier 5 Surgeries such as total knee/hip arthroplasty or lower back disk surgery.	We pay:	$625	$625	$1,250
Tier 6 Surgeries such as appendectomy, knee/shoulder reconstruction, or carpal tunnel surgery.	We pay:	$250	$250	$500
Tier 7 Surgeries such as removal of tonsils and adenoids, breast biopsy or creation of eardrum opening (tubes in ear).	We pay:	$125	$125	$250
Assistant Surgeon (payable per day, when a covered surgery requires)	We pay:	20% of surgical benefits (max 2 days)	20% of surgical benefits (max 2 days)	20% of surgical benefits (max 2 days)
Anesthesiologist (payable per day)	We pay:	30% of surgical benefits (max 2 days)	30% of surgical benefits (max 2 days)	30% of surgical benefits (max 2 days)

Benefits are subject to Preexisting Conditions. **See page 11** for details. [1]Relative value unit (RVU) is the value of service/procedure relative to all other service /procedures based upon the work, practice expense, and malpractice expense. These are established by the Centers for Medicare and Medicaid Services (CMS). Specific tier mapping and reimbursement amount is determined by the surgery's Current Procedural Terminology (CPT) code. [2] Surgery means an invasive diagnostic procedure performed by a doctor while the covered person is under anesthesia; or the treatment of a covered person's illness or injury by manual or instrumental operations, performed by a doctor while the covered person is under general, regional, or local anesthesia, or conscious sedation. Surgery does not include: blood draws, tattoos or tattoo removal, cosmetic treatment (unless part of reconstructive surgery), injections (other than spinal injections), experimental or investigational treatment, pregnancy and childbirth, or colonoscopy procedures. Anesthesia does not include topical anesthetic.

More ways to help you save money

Included with all plans is access to unlimited $0 virtual doctor visits through HealthiestYou[1] and discounts on prescription drugs through Optum Perks.

Telehealth - HealthiestYou by Teladoc Health[1]

Not feeling well, but not sure you want to go to the doctor? The telehealth benefit provided through HealthiestYou by Teladoc® Health makes it easy to see a doctor without leaving home. Just meet with a doctor by phone or video at no extra charge to you. They can diagnose and treat illnesses and prescribe medication when necessary 24/7/365. **Unlimited visits. No additional cost**. That's access to quality health care without the hassle.

Note: For additional fees, visits with psychiatrists, psychologists and dermatologists are also available.

Rx discounts with Optum Perks[2]

There's a simple way to save **30-80% on prescription drugs** with an Optum Perks prescription drugs discount card. Just visit **perks.optum.com/uho** to print your card or send it to your phone. While there you can also compare prescription drug prices at stores near you. To use your savings, show your Optum Perks discount card to the pharmacy during purchase.

Note: The Optum Perks card is not insurance. It is a discount program only and available to the general public.

Nationwide network of savings[3]

You can use any provider you choose for medical services, but you'll get the most out of your benefits when you use the UnitedHealthcare Choice Plus network with an average of 58% savings. Visit **uhone.com** and select "Find A Doctor" to search for network providers in your state.

Note: If you have a major medical plan, you may need to stay with certain networks and providers to get the most coverage out of that plan.

[1] HealthiestYou by Teladoc Health and UnitedHealthcare are not affiliated and each entity is responsible for its own contractual and financial obligations. This specific program is not insurance; no benefits are payable for the use of this service. [2] Based on pharmacy's usual and customary price. Actual savings may vary. [3] Average savings is based on 2023 E&I Healthcare Econ & Pricing data of UnitedHealthcare Choice Plus network; average across combined in-patient and outpatient services. Savings experience can vary by provider and service.



UHC Member Hub

Manage your Guard plan with UHC Member Hub

Connecting with your plan

With UHC Member Hub, you can manage your plan at your convenience, anytime day or night. Once registered for this member website, you can:

- Access your plan documents
- View and download your ID card
- Make changes to your contact information
- Look up network doctors and hospitals
- Make premium payments
- Submit claims
- Send secure, non-urgent questions about your coverage

UHC Member Hub is a fast and easy way to get many of your questions answered, and manage your plan without having to make a phone call. Go to **uhcmemberhub.com**.

Exclusions and/or Limitations

This is only a general outline of the basic policy provisions and exclusions. State-specific differences may apply. It is not an insurance contract, nor part of the insurance policy. You will find complete details in the policy.

THE POLICY MAY LIMIT OR EXCLUDE BENEFITS FOR ANY LOSS CAUSED BY, RESULTING FROM, FOR, OR RELATING TO ANY OF THE FOLLOWING:

- A loss occurring before the policy effective date, after termination of the policy, during any time that coverage is not in force.
- Any act of war; intentionally, self-inflicted, bodily harm; or participation in a riot; or commission or attempt to commit a felony.
- Active service in the armed forces or related auxiliaries.
- A covered person being intoxicated as defined by applicable state law or under the influence of narcotics or controlled substances or taking over the counter drug other than as the recommended dosage.
- Cosmetic treatment.
- Pregnancy or childbirth (except for complications of pregnancy or as required by a state).
- Hospital confinement that begins on a Friday or Saturday unless it is an emergency, or medically necessary inpatient surgery is scheduled for the day after the date of admission.
- Hospital confinement primarily to receive rehabilitation, custodial care, educational care, or nursing services (unless expressly provided for by the policy).
- Any injury sustained while paid to participate or instruct in: horseback riding, racing or speed testing any non-motorized vehicle/conveyance, skiing, or rock or mountain climbing.
- Any injury sustained while participating, demonstrating, instructing, guiding, or accompanying others in: sports (semi- or professional or intercollegiate not including intramural sports), parachute jumping, hang gliding, skydiving, bungee jumping, parakiting, racing or speed testing any motorized vehicle/conveyance, rodeo sports, or scuba/skin diving (60 or more feet in depth).
- Operating a taxi or any other passenger transportation for wage, compensation, or profit.
- Routine well-baby care of a newborn infant while inpatient, except as expressly provided for by the policy.
- Infertility treatment.
- Sexual reassignment surgery.
- Injuries sustained while operating, riding in, or descending from any type of non-commercial aircraft. In most states, this is only excluded if the covered person is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
- Services performed by an immediate family member.
- Expenses/surcharges imposed by a provider (including a hospital), but which are actually the responsibility of the provider to pay.
- Services or supplies that are not medically necessary to the diagnosis or treatment of an illness or injury.
- Any loss sustained while the covered person is incarcerated in any prison or other detention facility.
- Any loss related to the treatment of mental disorders or substance abuse.
- Any loss related to an abortion (unless the life of the mother would be endangered if the fetus were carried to term).
- Any loss for dental expenses, except as expressly provided for by the policy.
- Any loss related to any examination or fitting related to eyeglasses, contact lenses, hearing aids, eye refraction, or visual therapy.
- Any services rendered outside of the U.S., except for emergency treatment for a covered person.
- Experimental or investigational treatment(s).

Plan Provisions

This is only a general outline of the basic policy provisions and exclusions. State-specific differences may apply. It is not an insurance contract, nor part of the insurance policy. You will find complete details in the policy.

THIS IS NOT QUALIFYING HEALTH CARE COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT.

Eligibility

At time of application, the primary insured and spouse (as defined by state) must be between 18-64 years of age (drop off on 65th birthday), or as required by state. Eligible children must be 0-25 years of age (drop off on 26th birthday), or as required by state.

Misstatement of Age, Gender, or Tobacco Use

If the covered person's age, gender, or use of tobacco has been misstated on the covered person's application for coverage under the policy, any future premiums may be adjusted and past premiums may be refunded or owed to us based on the correct age, gender or tobacco status. If a covered person's age has been misstated and we would not have issued coverage for that covered person, we will refund the premium paid minus any benefit amounts paid by us, and coverage would be void from the effective date.

Notice of Claim

We must receive notice of claim within 30 days of the date the loss began or as soon as reasonably possible.

Premium

Premium rates are guaranteed for 12 months then subject to change. The age, gender, and tobacco class of a covered person and type and level of coverage are some factors that could be used to determine your premium rate. You will be given at least a 31-day notice (or longer if required by your state) of any change in your premium.

We will make no change in your premium solely because of claims made by a covered person under the policy or a change in a covered person's health.

Preexisting Conditions

We will not pay benefits under the policy for a loss which manifests due to, results from, is caused by, or contributed to by a Preexisting Condition. The Preexisting Condition limitation will not apply longer than 12 months (or as required by state) after a covered person's applicable effective date under the policy.

"Preexisting Condition" means an illness, injury or condition:

- For which medical advice, diagnosis, care, or treatment was recommended to or received by a covered person within 12 months immediately preceding the effective date the covered person became insured under the policy; or
- That manifested symptoms which would cause an ordinarily prudent person to seek diagnosis or treatment within the 12 months immediately preceding the applicable effective date the covered person became insured under the policy.

Renewability and Termination

The policy is renewable until the earliest of the following:

- The primary insured's 65th birthday (or next premium due date, dependent on state) or death. If the policy includes dependents, it may be continued after the primary insured's death or 65th birthday:
  - By the spouse, if a covered person;
  - Otherwise, by an eligible child who is a covered person;
- Nonpayment of premiums when due;
- The date we discontinue offering and refuse to renew all policies issued on this form for all residents of the state where you reside;
- The date we receive a request from you to terminate the policy; or
- The date there is fraud or a material misrepresentation made by or with the knowledge of a covered person.

Plan Provisions (continued)

This is only a general outline of the basic policy provisions and exclusions. State-specific differences may apply. It is not an insurance contract, nor part of the insurance policy. You will find complete details in the policy.

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 "free look." After applying and after your policy is issued, if you are not satisfied the coverage will meet your insurance needs, you may return the policy to us within 10 days (or as required by state) and have the paid premium refunded. Refer to policy for details.

Underwriting

Insurance plans are subject to health underwriting. If you provide incorrect or incomplete information on your application for insurance your coverage may be voided or claims denied.

State Variations

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

Alabama

Policy Form HPG3-CSTM-GRI-01

- Misstatement of Gender or Tobacco Use provision does not apply.

Alaska

Policy Form HPG3-CSTM-GRI-50

- In the Premium Change provision, you will be given at least a 45-day notice of changes.

Arizona

Policy Form HPG3-CSTM-GRI-02

- The exclusion for services performed by a member of the covered person's immediate family does not apply.
- The exclusion for loss sustained while covered person is incarcerated is limited to incarceration in state or federal prison.

Arkansas

Policy Form HPG3-CSTM-GRI-03

- The exclusion for any loss related to substance abuse only applies to drug use disorder or for treatment programs for drug use disorder.

Colorado

Policy Form HPG3-CSTM-GRI-05

- Spouse means the person to whom you are legally married or your partner in a civil union under Colorado law.
- The exclusion for self-inflicted bodily harm only applies if the covered person is sane.
- The exclusion as a result of any injury sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in racing or speed testing any motorized vehicle or conveyance only applies if the covered person is paid to participate or instruct.
- The exclusion does not apply for Preexisting Condition that manifested symptoms that would cause an ordinarily prudent person to seek diagnosis or treatment within the 12 months immediately preceding the applicable effective date the covered person became insured under the policy.

Delaware

Policy Form HPG3-CSTM-GRI

- Maximum issue age is 60.

Florida

Policy Form HPG3-CSTM-GRI-09

- Eligible child may also include your or your spouse's child who is under age 31 if they are unmarried, and not covered by any other health benefit plan.
- The exclusion for hospital confinement that begins on a Friday or Saturday unless it is an emergency, or medically necessary inpatient surgery is scheduled for the date after the date of admission, does not apply.
- In the Premium Change provision, you will be given at least a 45-day notice of changes.

Georgia

Policy Form HPG3-CSTM-GRI-10

- In the Premium Change provision, you will be given at least a 60-day notice of changes.

Hawaii

Policy Form HPG3-CSTM-GRI-51

- There are no state variations.

Illinois

Policy Form HPG3-CSTM-GRI-12

- Eligible child may also include your or your spouse's child who is under age 30, who has served in the United States Armed Forces, has been released or discharged other than a dishonorable discharge, and has submitted his/her DD-214 to us (GRIC) stating the date on which the dependent was released from service.
- Spouse means the person to whom you are legally married or your partner in civil union under Illinois law. Party to a civil union means a person who has established a civil union pursuant to the Illinois Religious Freedom Protection and Civil Union Act.
- The exclusion for any injury sustained while participating, demonstrating, instructing, guiding, or accompanying others in certain activities (i.e. semi- and professional sports, parachuting, rodeo sports, etc) or any injury while paid to participate or instruct in certain activities (i.e. horseback riding, racing etc.) does not apply.

State Variations (continued)

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

Illinois (continued)

- The references to misstatements or misrepresentations refer to "intentional" misstatements or misrepresentations.

Indiana

Policy Form HPG3-CSTM-GRI-13

- There is a 30-day right to examine period.

Iowa

Policy Form HPG3-CSTM-GRI-14

- There are no state variations.

Kentucky

Policy Form HPG3-CSTM-GRI-16.

- In the Notice of Claim provision, we must receive notice of claim within 60 days of the date of loss or as soon as reasonably possible.

Lousiana

Policy Form HPG3-CSTM-GRI-17

- There is a 30-day right to examine period.
- The exclusion for a loss sustained while the covered person is incarcerated in a state or federal prison or other detention facility does not apply if a covered person is detained in a correctional facility and has not been adjudicated or convicted of a criminal offense.
- In the Premium Change provision, you will be given at least a 45-day notice of changes.

Maine

Policy Form HPG3-CSTM-GRI-18

- Spouse means the person to whom you are legally married or your domestic partner.
- In the Premium Change provison, you will be given at least a 60-day notice of changes.

Michigan

Policy Form HPG3-CSTM-GRI-21

- The following exclusions do not apply:
  - For intentionally self-inflicted bodily harm.
  - For participation in a riot.
  - For a covered person being intoxicated as defined by applicable state law or under the influence of narcotics or controlled substances or taking over the counter drug other than as the recommended dosage.
- There is an exclusion for any illness or injury incurred as a result of the covered person's committing or attempting to commit a misdemeanor or felony, whether or not charged, or which a contributing cause was the covered person's being engaged in an illegal occupation or other willful criminal activity.

Minnesota

Policy Form HPG3-CSTM-GRI-22

- There are no state variations.

Mississippi

Policy Form HPG3-CSTM-GRI-23

- Misstatement of Age, Gender, or Tobacco Use does not apply.
- In the Premium Change provision, you will be given at least a 60-day notice of changes.

Missouri

Policy Form HPG3-CSTM-GRI-24

- The exclusion for intentionally self-inflicted bodily harm does not apply if the person was insane.
- The exclusion for loss sustained while incarcerated does not apply.
- The Preexisting Condition limitation will not apply to an eligible child legally placed for adoption with you or your spouse.

Nebraska

Policy Form HPG3-CSTM-GRI-26

- The exclusions for any injury sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in racing or speed testing any motorized or non-motorized vehicle or conveyance apply only to organized racing or speed testing.
- "Preexisting Condition" means an illness, injury or condition for which medical advice, diagnosis, care, or treatment was recommended to or received by a covered person within 12 months immediately preceding the effective date the covered person became insured under the policy.

State Variations (continued)

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

Nevada

Policy Form HPG3-CSTM-GRI-27

- Spouse means the person to whom you are legally married or your domestic partner.
- The exclusion does not apply for a covered person being intoxicated as defined by applicable state law or under the influence of narcotics or controlled substances or taking over the counter drug other than as the recommended dosage.
- "Preexisting Condition" means an illness, injury or condition:
  - For which medical advice, diagnosis, care, or treatment was recommended to or received by a covered person within 6 months immediately preceding the effective date the covered person became insured under the policy; or
  - That 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.
- In the Premium Change provision, you will be given at least a 60-day notice of changes.

North Carolina

Policy Form HPG3-CSTM-GRI-32

- The exclusion for loss as a result of any act of declared or undeclared war does not apply to acts of terrorism.
- The exclusion for cosmetic treatment does not apply to congenital defects and anomalies. "Preexisting Condition" means those conditions for which medical advice, diagnosis, care, or treatment was recommended to or received by a covered person within 12 months immediately preceding the effective date the covered person became insured under the policy.
- In the Premium Change provision, you will be given at least a 45-day notice of changes.

Oklahoma

Policy Form HPG3-CSTM-GRI-35

- There is a 30-day right to examine period.
- The exclusion for act of war applies to: Any act of declared or undeclared war while serving in the military or naval service, or any auxiliary unit of the United States, including but not limited to: 1. Service as a member of a Regular or Reserve component of the U.S. Army, Air Force, Navy, Coast Guard, or Marine Corps; 2. Service as a commissioned officer of the Public Health Service or National Oceanic and Atmospheric Administration; or 3. Military or naval service in an auxiliary military organization, including but not limited to the Coast Guard Auxiliary, the temporary Coast Guard Reserve, the Civilian Auxiliary to the Military Police or the Civil Air Patrol.
- The exclusion for intoxication is replaced with: A loss sustained while under the influence of illegal narcotics or controlled substance unless administered or prescribed by a doctor.
- The exclusion for operating a taxi or passenger transportation does not apply.
- The exclusion for any injury sustained while participating, demonstrating, instructing, guiding, or accompanying others in certain activities (i.e. semi- and professional sports, parachuting, rodeo sports, etc) or any injury while paid to participate or instruct in certain activities (i.e. horseback riding, racing etc.) does not apply.

Rhode Island

Policy Form HPG3-CSTM-GRI-38

- Spouse means the person to whom you are legally married or your partner in a civil union under Rhode Island Law.

South Carolina

Policy Form HPG3-CSTM-GRI-39

- There is a 30-day right to examine period.
- The exclusion does not apply for a loss incurred as a result of the covered person being intoxicated, as defined by applicable state law or under the influence of illegal narcotics or controlled substances or taking over the counter drug other than as the recommended dosage.

State Variations (continued)

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

Tennessee

Policy Form HPG3-CSTM-GRI-41

- Chiropractic visits are reimbursed as Doctor Office Visits and do not include the separate benefit for Chiropractic Visits under Therapy Visits.
- The exclusion for loss related to performance of an abortion is replaced with: Any loss related to the performance of an abortion (unless the life of the mother would be endangered if the fetus were carried to term or when the fetus is not viable).

Texas

Policy Form HPG3-CSTM-GRI-42(R)

- The following exclusions do not apply:
  - Hospital confinement for the first Friday or Saturday of an inpatient stay that begins on one of those days, unless it is an emergency, or medically necessary inpatient surgery is scheduled for the date after the date of admission.
  - Any injury sustained while paid to participate or instruct in: horseback riding, racing or speed testing any non-motorized vehicle/conveyance, skiing, or rock or mountain climbing.
  - Any injury sustained while participating, demonstrating, instructing, guiding, or accompanying others in: sports (semi- or professional or intercollegiate not including intramural sports), parachute jumping, hang gliding, skydiving, bungee jumping, parakiting, racing or speed testing any motorized vehicle/ conveyance, rodeo sports, or scuba/skin diving (60 or more feet in depth).
  - Services performed by a member of the covered person's immediate family.
  - Any services rendered outside of the United States, except for services rendered for emergency treatment of a covered person.

Utah

Policy Form HPG3-CSTM-GRI-43

- The following exclusions for any loss caused by, resulting from, for, or relating to any of the following do not apply:
  - Any injury sustained while paid to participate or instruct in: horseback riding, racing or speed testing any nonmotorized vehicle/conveyance, skiing, or rock or mountain climbing.
  - Any injury sustained while participating, demonstrating, instructing, guiding, or accompanying others in: sports (semi- or professional or intercollegiate not including intramural sports), parachute jumping, hang gliding, skydiving, bungee jumping, parakiting, racing or speed testing any motorized vehicle/ conveyance, rodeo sports, or scuba/skin diving (60 or more feet in depth).
- In the Premium Change provision, you will be given at least a 45-day notice of changes.

Virginia

Policy Form HPG3-CSTM-GRI-45

- The Misstatement of Gender and Tobacco Use provisions do not apply. If age is misstated benefits will be those the premium paid would have purchased at the correct age.
- In regards to the exclusion for cosmetic treatment, cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
- The exclusion for intoxication applies to a loss incurred as a result of the covered person being intoxicated, as defined by applicable state law in the state in which the loss occurred: from the insured being drunk or under the influence of any narcotics unless taken on the advice of a doctor.
- The exclusion for pregnancy or childbirth does not apply to pregnancy following an act of rape when reported to police within 7 days of occurrence; or up to 180 days for an act of rape or incest of a female under 13 years of age.
- The exclusion for an injury sustained while in a non-commercial aircraft applies only if operating the aircraft.
- The exclusion for any loss relating to the treatment of mental disorders or substance abuse is replaced with: Any loss related to the treatment of mental disorders, drug addiction and alcoholism.

State Variations (continued)

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

Virginia (continued)

- Office visit benefits are limited only to doctor office visits that do not relate solely to alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
- The following exclusions do not apply:
  - Active service in the armed forces or related auxiliaries.
  - Hospital confinement for the first Friday or Saturday of an inpatient stay that begins on one of those days, unless it is an emergency, or medically necessary inpatient surgery is scheduled for the day after the date of admission.
  - Sexual reassignment surgery.
  - Infertility treatment.
  - Operating a taxi or any other passenger transportation for wage, compensation, or profit.
  - Any injury sustained while paid to participate or instruct in: horseback riding, racing or speed testing any non-motorized vehicle/conveyance, skiing, or rock or mountain climbing.
  - Any injury sustained while participating, demonstrating, instructing, guiding, or accompanying others in: sports (semi- or professional or intercollegiate not including intramural sports), parachute jumping, hang gliding, skydiving, bungee jumping, parakiting, racing or speed testing any motorized vehicle/conveyance, rodeo sports, or scuba/skin diving (60 or more feet in depth).
  - Any loss sustained while the covered person is incarcerated in a state or federal prison or other detention facility.
  - Experimental or investigational treatment(s).

West Virginia

Policy Form HPG3-CSTM-GRI-47

- There are no state variations.

Wisconsin

Policy Form HPG3-CSTM-GRI-48

- An Outline of Coverage for this state, HPG3-OC-CSTM-GRI-48, can be viewed at https://stage.uhone.com/api/supplysystem/?Filename=52002OCWI-G202506.pdf
- "Preexisting Condition" means an illness, injury or condition misrepresented or not fully disclosed on the application for insurance:
  - For which medical advice, diagnosis, care, or treatment was recommended to or received by a covered person within 12 months immediately preceding the effective date the covered person became insured under the policy; or
  - That manifested symptoms which would cause an ordinarily prudent person to seek diagnosis or treatment within the 12 months immediately preceding the applicable effective date the covered person became insured under the policy.
- In the Premium Change provision, you will be given at least a 60-day notice of changes.

Wyoming

Policy Form HPG3-CSTM-GRI-49

- The Misstatement of Gender and Tobacco Use provisions do not apply.
- "Preexisting Condition" means an illness, injury or condition for which medical advice, diagnosis, care, or treatment was recommended to or received by a covered person within 6 months immediately preceding the effective date the covered person became insured under the policy.
- In the Notice of Claim provision, we must receive notice of claim within 60 days of the date of loss or as soon as reasonably possible.

Note to our customers about supplemental insurance

- The supplemental plan discussed in this document is separate from any health insurance or Medicare Advantage coverage you may have purchased with another insurance company
- This plan provides optional coverage for an additional premium. It is intended to supplement your health insurance and provide additional benefits for covered expenses.
- This plan is not required in order to purchase health insurance with another insurance company
- This plan should not be used as a substitute for comprehensive health insurance coverage. It is not considered Minimum Essential Coverage under the Affordable Care Act.

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)

Conditions prior to coverage (applicable with or without the conditional receipt)

Subject to the limitations shown below, insurance will become effective if the following conditions are met:

1. The application is completed in full and is unconditionally accepted and approved by Golden Rule Insurance Company
2. The first full premium, according to the mode of premium payment chosen, has been paid on or prior to the effective date and any check is honored on first presentation for payment
3. The policy is: (a) issued by Golden Rule Insurance Company exactly as applied for within 45 days from date of application; (b) delivered to the proposed insured; and (c) accepted by the proposed insured

After you have completed the application and before you sign it, reread it carefully. Be certain that all information has been properly recorded. Keep an electronic copy of this document. It has important information.

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