UnitedHealthOne℠

Short Term Medical℠ Plans

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

Short Term Medical℠ plans do not provide:

- Coverage for preexisting conditions;
- Mandated coverage necessary to avoid a penalty under the Affordable Care Act.

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UnitedHealthOne℠

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.

Policy Forms C-014.1 and state variations, GRI-STAG15-C-VAL-02 and state variations, GRI-STAG15-C-PLS-02 and state variations, GRI-STAG15-C-PLE-02 and state variations, GRI-STAG15-C-CPY-02 and state variations, and GRI-STAG15-C-CPV-02 and state variations.

UnitedHealthOne℠

experience
NEARLY 70 YEARS IN THE BUSINESS OF INSURING INDIVIDUALS

fast claims
94% OF CLAIMS PROCESSED IN 12 DAYS OR LESS[2]

our network
NATIONWIDE NETWORK CAN MEAN BIG SAVINGS

Why choose us?

You are the One with UnitedHealthOne℠

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

Strength & Experience

UnitedHealthcare Employer and Individual provides nearly 29 million Americans access to health care.[1] We offer an array of consumer-oriented health benefit plans.

Highly Rated

Golden Rule Insurance Company is rated "A" (Excellent) by A.M. Best (12-11-14). 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.

Outstanding Claims Service

Our employees who process claims have a long history of fast service.
The results – 94% of all health claims are processed within 12 working days or less.[2]

Nationwide Network – Big Savings

With a network provider, you will not be balance billed for eligible expenses. Health care professionals in our network agree to provide you quality care at lower fees. With access to over 850,000 physicians and other health care professionals, and approximately 6,100 hospitals and other facilities,[1] chances are your current doctor is already a part of our nationwide network.

Visit *www.UnitedHealthOne.com/doctor* to find providers in the UnitedHealthcare Choice Plus network.

[1] UnitedHealth Group Annual Form 10-K for year ended 12/31/14.
[2] Actual 2014 results.

UnitedHealthcare Choice Plus Network

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

Sample Savings With Our Network (Services provided 03/2014-08/2014)[1]

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

Benefit	Actual Charges	Network Repriced Charges	Network Savings
Doctor Office Visit - established patient	$74.70	$43.29	**42%**
MRI	$939.14	$316.00	**66%**
Lipid Panel (Cholesterol)	$35.69	$4.33	**88%**
CBC (Complete Blood Count)	$32.92	$5.17	**84%**
Metabolic Panel (Blood sugar/kidney and liver function)	$25.38	$3.54	**86%**
General Panel (General blood work)	$175.30	$18.73	**89%**

Nonemergency covered expenses

Using non-network providers you pay:[2]

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

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

[1] All these services were received from network providers in ZIP Code 730--. Your actual savings may be more or less than this illustration. Discounts vary by provider, geographic area, and type of service.

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

How our plans work

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

A Choice of Coverage to Fit Your Specific Needs

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

PLANS AT A GLANCE	1 PLAN FEATURES	2 COVERED EXPENSES	3 WHO BENEFITS MOST?
Lifetime Maximum Benefit: $1,000,000 Short Term Medical℠ **Value**	• Our lowest premium plan. • In exchange, you take more responsibility for medical expenses. • No Rx drug coverage.	• Pay selected deductible. • Then pay coinsurance, (select from 2 options) up to: - $5,000 per term/cause, or - $10,000 per term/cause.	Consumers looking for minimal coverage.
Lifetime Maximum Benefit: $1,000,000 Short Term Medical℠ **Plus**	• More coverage than Value. • Rx drug coverage included. • Option to add a $20 copay on generic Rx drugs.	• Pay selected deductible. • Then pay coinsurance, (select from 2 options) up to: - $2,000 per term/cause, or - $5,000 per term/cause.	Great for those seeking predictable out-of-pocket expenses.
Lifetime Maximum Benefit: $1,000,000 Short Term Medical℠ **Copay Value**	• Copay for network doctor office visits.[2] • No Rx drug coverage. • Option to add Rx drug coverage or a $20 copay on generic Rx drugs.	• Pay selected deductible. • Then pay coinsurance, up to $10,000 per term/cause.	Families with young children who have regularly scheduled doctor office visits.
Lifetime Maximum Benefit: $1,000,000 Short Term Medical℠ **Copay**	• Copay for network doctor office visits.[2] • Rx drug coverage included. • Options to remove Rx drug coverage, add a 4-Tier Rx drug card, or add a $20 copay on generic Rx drugs.	• Pay selected deductible. • Then pay coinsurance, up to $10,000 per term/cause.	Anyone who prefers the convenience of copay benefits for minor or routine health care expenses.
Lifetime Maximum Benefit: $1,500,000 Short Term Medical℠ **Plus Elite**[3]	• Increased lifetime maximum benefit up to $1.5 million. • Rx drug coverage included. • Option to add a $20 copay on generic Rx drugs.	• Pay selected deductible. • Then pay coinsurance, (select from 2 options) up to: - $2,000 per term/cause, or - $5,000 per term/cause.	Great for those seeking predictable out-of-pocket expenses and for those who are considering longer term lengths.

[1] 30-184 days in AZ, IN, MI, OK, and VA.
[2] History and exam only: 2 visit limit for terms 180 days or less; 4 visit limit for terms 181 days and over. Additional visits subject to deductible and coinsurance.
[3] Not available in all states.

Optional Benefits

Further customize your health insurance coverage to meet your specific needs.

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

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

Per Cause Deductible Option

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

Supplemental Accident Optional Benefit

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

Benefit Amounts:	$1,000	$1,500	$2,500	$5,000	$10,000

Savings example for $60,000 open-arm fracture*	No health plan	Short Term Medical℠ Copay plan only ($5,000 deductible + 30% coinsurance)	Same plan with a $5,000 Supplemental Accident Benefit
What you could pay:	$60,000	$15,000	$10,000

* Examples provided are for illustration purposes only and assume all expenses are covered. Adding a $5,000 Supplemental Accident Benefit would add $30 in monthly premium for a single person and $60 in monthly premium for a family. All of these services were received in April 2014 from network providers in ZIP Code 322--. Your actual savings may be more or less than this illustration and will vary by several factors. Policy Form 6-C-410

Supplemental Accident Provisions

Expenses must be eligible for payment under the health insurance and incurred within 90 days of an injury. Benefit cannot exceed your total covered medical out-of-pocket expenses that are neither paid nor reimbursed by the underlying health insurance.
Any benefit amount paid by the Supplemental Accident benefit will first be credited to the deductible and coinsurance of the health insurance. The payment will be made either to your health care provider under your assignment of benefits, or to you if you have already paid your provider. No cash payments to the insured except for reimbursement of submitted claims for covered expenses already paid by you and not paid by the underlying health insurance. Exclusions and Limitations of the health plan apply to this additional benefit.

1 **Choose a plan.**
You have several choices.

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

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

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

Highlights of Network Covered Expenses

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

[1] Not available in all states.
[2] 30-184 days in AZ, IN, MI, OK, and VA.
[3] 30-184 days in AZ, IN, MI, and OK.
[4] For copay plans, non-network office visits subject to deductible and coinsurance, $50 copay does not apply.
[5] Generic Rx drugs only. Deductible does not apply.

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Short Term Medical℠ can "bridge the gaps" in health insurance coverage.

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Covered Expenses

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

Ambulance Services

Ground ambulance service to a hospital for necessary emergency care.

Autism Spectrum Disorders

Treatment of autism spectrum disorders. Outpatient applied behavior analysis limited to $50,000 per calendar year, per covered person.

Dental Anesthesia

Dental anesthesia (excluding actual dental services) provided in a hospital or outpatient surgical facility and facility fees when the provider certifies that due to the patient's age or condition, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures. The covered person must:

- Be under 7 years of age requiring, without delay, necessary dental treatment for a significantly complex dental condition;
- Be diagnosed with a serious mental or physical condition; and/or
- Have a significant behavioral problem.

No benefits payable for treatment of temporomandibular joint (TMJ) disorders.

Dental Services

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 as limited in the policy.

Diabetes

- Diabetes equipment, supplies, and services.
- Diabetes self-management training when medically necessary as determined by a physician, prescribed by a physician, and provided by an appropriately licensed health care professional limited to:
  - One diabetes self-management training program per covered person, per lifetime.
  - Additional diabetes self-management training prescribed by a physician as medically necessary due to a significant change in the covered person's symptoms or condition.

Diagnostic Testing

Durable Medical Equipment

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

Home Health Care

Home health care prescribed and supervised by a doctor and provided by 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. 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 of registered nursing).

No benefits payable for respite care, custodial care, or educational care.

Hospital Services

Daily hospital room and board at most common semiprivate rate; eligible expenses for an intensive care unit; inpatient use of an operating, treatment, or recovery room; outpatient use of an operating, treatment, or recovery room for surgery; services and supplies, including drugs and medicines, which are routinely provided in the hospital to persons for use only while they are inpatients; emergency treatment of an injury, even if not admitted; and emergency treatment of an illness, but if not admitted for that illness, emergency room charges will not be covered.

Hospital does not include a nursing or convalescent home or an extended care facility.

Medical Supplies

- Dressings and other necessary medical supplies.
- Cost and administration of an anesthetic or oxygen.

Mental Disorders and Substance Abuse

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

Mental disorders and substance abuse are not covered with the Short Term Medical[SM] Value plan.

Newborn Care

- Routine in-hospital care of a newborn limited to the first 5 days following birth or when the mother ceases to be an inpatient, whichever occurs first.
- Pregnancy not covered, except for complications.

Outpatient Surgery

Physician Fees

- Professional fees of doctors, medical practitioners, and surgeons.
- Assistant surgeon fee limited to 20% of eligible expenses of the procedure.

Prescription Drugs (if applicable)

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

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

Preventive Care

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

Prosthetics

Basic artificial limbs, artificial eyes, and larynx and breast prosthesis. Replacement only if required by a physical change in the covered person and the item cannot be modified.

Rehabilitation and Extended Care Facility (ECF)

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

Spine and Back Disorders

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

Therapeutic Treatments

- Radiation therapy and chemotherapy.
- Hemodialysis, processing, and administration of blood or components (but not the cost of the actual blood or components).

Transplant Expense Benefit

The following transplants are covered the same as any other illness: cornea, artery or vein grafts, heart valve grafts, prosthetic tissue and joint replacement, and prosthetic lenses for cataracts.

For all other covered transplants, see your 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 10-year period, per covered person.

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

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

No benefits payable for:

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

General Exclusions

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

No benefits are payable for expenses:

- For a preexisting condition — A condition: (1) for which medical advice, diagnosis, care, or treatment was recommended or received within the 24 months immediately preceding the date the covered person became insured under the policy/certificate; or (2) that had manifested itself in such a manner that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment within the 12 months immediately preceding the date the covered person became insured under the policy/certificate.

  A pregnancy existing on the effective date of coverage will also be considered a preexisting condition.

  NOTE: Even if you have had prior Golden Rule coverage and your preexisting conditions were covered under that plan, they will not be covered under this plan.
- That would not have been charged if you did not have insurance.
- Incurred while your coverage is not in force.
- Imposed on you by a provider (including a hospital) that are actually the responsibility of the provider to pay.
- For services performed by an immediate family member.
- That are not identified and included as covered expenses under the policy or in excess of the eligible expenses.
- For services that are not covered expenses.
- For services or supplies that are provided prior to the effective date or after the termination date of the coverage.
- For weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.
- For breast reduction or augmentation.
- For drugs, treatment, or procedures that promote conception.
- 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.
- For modification of the physical body in order to improve psychological, mental, or emotional well-being, such as sex-change surgery.
- Not specifically provided for in the policy, including telephone consultations, failure to keep an appointment, television expenses, or telephone expenses.
- For marriage, family, or child counseling.
- For standby availability of a medical practitioner when no treatment is rendered.
- For dental expenses, including braces and oral surgery, except as provided for in the policy.
- For cosmetic treatment.
- For reconstructive surgery unless incidental to or following surgery or for a covered injury, or to correct a birth defect in a child who has been a covered person since childbirth until the surgery.
- For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems.
- For diagnosis or treatment of nicotine addiction.
- For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under Transplant Services.
- For injuries from participation in professional or semi-professional sports or athletic activities for financial gain, as determined by Golden Rule.
- For high-dose chemotherapy prior to, in conjunction with, or supported by ABMT/BMT, except as specifically provided under the Transplant Expense Benefits provision.
- For eye refractive surgery, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
- While confined for rehabilitation, custodial care, educational care, nursing services, or while at a residential treatment facility, except as provided for in the policy.
- For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or any exam or fitting related to these devices, except as provided for in the policy.
- Due to pregnancy (except complications), except as provided in the policy.
- For diagnostic testing while confined primarily for well-baby care, except as provided in the policy.
- For treatment of mental disorders, or court-ordered treatment for substance abuse, except as provided in the policy.

General Exclusions, continued

No benefits are payable for expenses:

- For preventive care or prophylactic care, including routine physical examinations, premarital examinations, and educational programs, except as provided in the policy.
- Incurred outside of the U.S., except for emergency treatment.
- Resulting from declared or undeclared war; intentionally self-inflicted bodily harm (whether sane or insane); or participation in a riot or felony (whether or not charged).
- For or related to durable medical equipment or for its fitting, implantation, adjustment or removal or for complications therefrom, except as provided for in the policy.
- For surrogate parenting
- For treatments of hyperhidrosis (excessive sweating).
- For alternative treatments, except as specifically covered by the policy, including: acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing, and other alternative treatments defined by the Office of Alternative Medicine of the National Institutes of Health.
- 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. Should a workers' compensation insurance carrier deny coverage for a covered person's claim, this exclusion will still apply unless the denial is appealed and upheld to the proper government agency.
- Resulting from intoxication, as defined by state law where the illness or injury occurred, or while under the influence of illegal narcotics or controlled substances, unless administered or prescribed by a doctor.
- For vocational or recreational therapy, vocational rehabilitation, outpatient speech therapy, or occupational therapy, except as provided for in the policy.
- Resulting from experimental or investigational treatments, or unproven services.

Coordination of Benefits (including Medicare)

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

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

Dependents

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

Effective Date

Your certificate will take effect on the later of:

- The requested effective date on your application; or
- The day after the postmark date affixed by the U.S. Postal Service,* but only if the following conditions are satisfied:
  - A. Your application and the appropriate premium payment are actually received by us within 15 days of your signing;**
  - B. You are a member of the Federation of American Consumers and Travelers (FACT);
  - C. Your application is properly completed and unaltered;
  - D. You have answered "no" to question 2 (if other questions are answered "yes," we will exclude the person(s) listed);
  - E. You are a resident of a state in which the certificate form can be issued; and
  - F. If the application is submitted by an agent or broker, the agent or broker is properly licensed and appointed to submit applications to Golden Rule.

* If mailed and not postmarked by the U.S. Postal Service or if the postmark is not legible, the effective date will be the later of: (1) the date you requested; or (2) the date received by Golden Rule. If the application is sent by any electronic means including fax, your coverage will take effect on the later of: (1) the requested effective date; or (2) the day after the date received by Golden Rule.

** Your account will be immediately charged.

Eligible Expense

An eligible expense means a covered expense as follows:

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

Non-Renewable

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

We may cancel coverage if there is fraud or material misrepresentation made by or with the knowledge of a covered person in filing a claim for benefits.

HEALTH PLAN NOTICES OF INFORMATION PRACTICES
MEDICAL INFORMATION PRIVACY NOTICE

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. (Effective January 1, 2015)

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 or 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.myuhone.com, www.myallsavers.com, www.myallsaversmember.com, or www.goldenrule.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 and to help manage your health care coverage. For example, we might conduct or arrange for medical review, legal services, and auditing functions, including fraud and abuse detection or compliance programs.
- **To Provide Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services.
- **To Plan Sponsors.** If your coverage is through an employer group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes.** We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use health information to contact you for appointment reminders with providers who provide medical care to you.

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

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

- **To Avoid a Serious Threat to Health or Safety** by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** including disclosures required by state workers' compensation laws that govern job-related injury or illness.
- **For Research Purposes** such as research related to the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information: HIV/AIDS; mental health; genetic tests; alcohol and drug abuse; sexually transmitted diseases and reproductive health information; and child or adult abuse or neglect, including sexual assault.

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

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, contact the phone number listed on your 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 upon request. In addition, you may obtain a copy of this notice at our websites such as *www.myuhone.com, www.myallsavers.com, www.myallsaversmember.com, or www.goldenrule.com.*
- **You have the right to be considered a protected person.** (New Mexico only) A "protected person" is a victim of domestic abuse who also is either: (i) an applicant for insurance with us; (ii) a person who is or may be covered by our insurance; or (iii) someone who has a claim for benefits under our insurance.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please call the toll-free phone number on your ID card.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed below.
- **Submitting a Written Request.** Mail to us your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record at the following address:
- Privacy Office, 7440 Woodland Drive, Indianapolis, IN 46278-1719
- **You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.** We will not take any action against you for filing a complaint.

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

MIB. In conjunction with our membership in MIB, Inc., formerly known as Medical Information Bureau (MIB), we or our reinsurers may make a report of your personal information to MIB. MIB is a not-for-profit organization of life and health insurance companies that operates an information exchange on behalf of its members. If you submit an application or claim for benefits to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply such company with information regarding you that it has in its file.

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

FINANCIAL INFORMATION PRIVACY NOTICE

(Effective January 1, 2015)

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

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

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

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

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

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

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

Questions About this Notice. If you have any questions about this notice, please **call the toll-free phone number on your ID card.**

The Notice of Information Practices, effective January 1, 2015, is provided on behalf of All Savers Insurance Company; All Savers Life Insurance Company of California; Golden Rule Insurance Company; PacifiCare Life and Health Insurance Company; 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.

Short Term Medical℠ Plans

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

Plans only available to members of FACT, the Federation of American Consumers and Travelers (see below). If you're not already a member, enroll now 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
- Consumer Information & Hotline
- 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.

This short term major medical policy is nonrenewable.

Short Term Medical℠ is issued for a specific period of time. If your needs for coverage extend beyond this plan, you may apply for additional short term plans.* This requires a new application and is not an extension of your current plan. Any illness or condition you develop while covered by your current plan would be considered "preexisting" when you apply for a new short term plan and, as such, will not be a covered expense.

Please see insert for state variations. In most cases, coverage will be determined by the master policy issued in Arkansas and subject to Arkansas law. We will notify you in advance of any changes in coverage or benefits. Not available in all states. Nonrefundable $20 application fee required.

* Not available in Wisconsin. In Michigan, no more than 184 days of combined coverage in a 12-month period.

UnitedHealthOne℠

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

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Short Term Medical℠ State Variations

Alabama
There are no state variations.

Arizona
Coverage term limited to 30-184 days.

Arkansas
Hearing aids are covered when purchased from a professional licensed by the state of Arkansas. Limited to $1,400 per ear in a 3-year period per covered person. No deductible, copayment, or coinsurance.

Florida
- An eligible child may remain covered through age 30.
- Routine follow-up care to determine whether a breast cancer has recurred in a person who has been previously determined to be free of breast cancer does not constitute medical advice, diagnosis, care or treatment for purposes of determining preexisting conditions unless evidence of breast cancer is found during or as a result of the follow up care.
- Transportation charges for a newborn to and from the nearest appropriate facility for medically necessary care limited to a maximum of $1,000.
- Covered expenses are expanded to include:
  - General anesthesia and services 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 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.

Illinois
- The definition of an eligible child is expanded to include an unmarried dependent under 30 years of age who: (a) Is an Illinois resident; (b) has served in the U.S. Armed Forces; (c) received a release or discharge other than dishonorable; and (d) has submitted a copy of a DD2-14 Certificate of Release or Discharge from active duty.
- The definition of "spouse" is expanded to include civil union partner.

Illinois, continued
- Covered Expenses are expanded to include:
  - Inpatient treatment of alcoholism.
  - Outpatient contraceptive services and devices as required by law.
  - Surveillance test for ovarian cancer for covered females at risk.
  - One annual FDA-approved screening for human papillomavirus. The cost and administration of FDA-approved human papillomavirus vaccine.
  - Habilitative services for covered person under age 19 diagnosed with a congenital, genetic, or early acquired syndrome. Treatment must be from licensed practitioners.
  - Medically necessary amino acid-based elemental formulas for the treatment of eosinophilic disorders or short bowel syndrome.
  - FDA-approved shingles vaccine, ordered by a doctor for persons age 60 and older.
  - Pain medication and therapy related to treatment of breast cancer to the same extent as any other illness.
  - Oral anti-cancer medication subject to the same cost-sharing requirements as intravenous or injected anti-cancer medication, regardless of the setting in which it is administered.
  - Routine patient care incurred by a covered person in a qualified cancer trial to the same extent as coverage for routine patient care for a covered person not enrolled in a qualified clinical cancer trial. Specific details included in the certificate.
  - For a female covered person, one clinical breast exam per calendar year.
  - Breast cancer screening (exempt from deductible, copayments, coinsurance, when provided by a network provider) limited to: one routine mammography exam per calendar year for each female covered person; additional mammograms at medically necessary intervals; and a comprehensive ultrasound when a mammogram shows heterogeneous or dense breast tissue.
- General Exclusions and Limitations are modified as follows: Covered expenses will not include, and no benefits will be paid for charges incurred for modification of the physical body in order to improve the psychological, mental, or emotional well-being of the covered person, except for charges for sex-change surgery or any other surgical or non-surgical treatment of gender dysphoria or gender identity disorder will be a covered expense, subject to all other limitations and exclusions of the policy.

Short Term Medical℠ State Variations, continued

Iowa
- The spine and back limitation does not apply.
- The definition of "spouse" is expanded to include a partner in a civil union or same sex marriage.

Michigan
Limited to coverage term of 30-184 days.

Mississippi
The references to 24 and 12 months in the definition of preexisting condition are both changed to 6 months.

Nebraska
There are no state variations.

North Carolina
- The definition of complications of pregnancy includes medically necessary fetal reduction.
- The definition of preexisting condition is replaced with: "Preexisting condition" means those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within the one-year period immediately preceding the effective date of the covered person's coverage. A pregnancy existing on the effective date of coverage will also be considered a preexisting condition.
- If your plan provides FDA-approved prescription drugs for certain types of cancer, coverage will not be excluded because the prescribed drug has not been FDA approved to treat a certain type of cancer. Full details included in your certificate.
- The General Exclusion provision for expenses resulting from intoxication or while under the influence of illegal narcotics or a controlled substance, will not apply.
- The General Exclusion provision for expenses incurred due to an injury or illness arising out of, or in the course of, employment for wage or profit is hereby deleted and replaced with the following: Covered expenses will not include services or supplies for the treatment of an occupational injury or illness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer, or worker's compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
- Under the Coordination of Benefits provision, the definition of plan will not include blanket, franchise individual, medical benefits under group or individual auto contracts, or homeowner coverage.
- Covered expenses are expanded to include:
  - General anesthesia, facility fees, and other related charges incurred in conjunction with dental care (but not the actual dental services) provided in a hospital or an outpatient surgical facility, when medically necessary to safely and effectively perform the procedure, for: an eligible child under 9 years of age; covered persons with serious mental or physical conditions or with significant behavioral problems.
  - Diagnosis and evaluation of osteoporosis or low bone mass for qualified individuals.
  - A newborn hearing screening when ordered by the attending doctor.
  - An annual screening for ovarian cancer using a transvaginal ultrasound and rectovaginal pelvic examination for women age 25 and older who are at risk for ovarian cancer.
  - Medically necessary costs of health care services associated with a clinical trial, medically necessary monitoring, and the diagnosis and treatment of complications to the extent these costs are not funded by national agencies, commercial manufacturers, distributors or other sponsors of participants in the clinical trial. Covered expenses do not include clinical trial costs of the actual investigational drug or device, services that are not health care services, services provided solely to satisfy data collection, services not provided for direct clinical management, or non-USFDA approved drugs provided after the clinical trial has been concluded.
  - Medically necessary services, equipment, supplies, medications, and laboratory procedures used in the treatment of diabetes, including self-management training.
  - Mammography screenings. Specific details in certificate at issue.
  - FDA-approved tests or screenings for the detection of the human papillomavirus (HPV).
  - Diagnosis, evaluation, and treatment of lymphedema, including equipment, supplies, and self-management training.

North Carolina, continued

- Covered expenses are expanded to include:
  - Medically necessary breast prosthesis.
  - Diagnostic, surgical and non-surgical treatment of temporomandibular joint disorders (TMJ), including splinting and use of intraoral prosthetic appliances. Non-surgical treatment of TMJ is limited to a lifetime maximum of $3,500 per covered person. Non-surgical treatment of TMJ disorders does not include tooth extraction, orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root implants, or root canals.

Ohio

- Short Term Medical℠ Plus Elite not available.
- Coverage eligibility for an eligible child is extended through age 27 if unmarried (until he or she turns 28).
- Transplant Expense Benefits are limited to 2 transplants per policy term. If a designated "Center of Excellence" is not used, covered expenses for a listed transplant will be limited to 1 transplant per policy term and a maximum benefit of $100,000 for all expenses associated with the transplant.
- Diagnosis or treatment of a mental disorder, including substance abuse, or for mental incapacity subject to the following additional limitations:
  - Outpatient treatment of substance abuse are further limited to $50 per visit for the fees of a medical practitioner.
  - Diagnosis and treatment of mental disorders on an outpatient basis will be limited to $550 per covered person, per policy term.

Oklahoma

- Coverage term limited to 30-184 days.
- The spine and back limitation does not apply.
- The General Exclusions provision for injury or illness by an act of declared or undeclared war is replaced with: No benefits payable for any charges which are caused by war or an act of war, declared or undeclared, while serving in the military or naval service, or any auxiliary unit of the United States.

Pennsylvania

There are no state variations.

Texas

- The definition of preexisting condition is replaced with: "Preexisting condition" means an injury or illness for which the covered person received medical advice or treatment within the 12 months immediately preceding the applicable effective date the covered person became insured under the policy. A pregnancy existing on the effective date of coverage will also be considered a preexisting condition.
- Inpatient chemical dependency is limited to a lifetime maximum of 3 separate series of treatments per covered person. No benefits payable for addiction or dependency on tobacco products or foods; outpatient detoxification; drug maintenance, as opposed to rehabilitation.
- Treatment of a mental disorder while under the supervision of a doctor of medicine or osteopathy in a psychiatric day treatment facility, or in a residential treatment center for children and adolescents or a crisis stabilization unit, will be covered the same as inpatient benefits for any other illness.
- Diagnosis and treatment of serious mental illness (as defined in the certificate) limited to: 45 days of inpatient treatment each calendar year; 60 outpatient visits each calendar year (not including medication management visits).
- Reconstructive surgery for craniofacial abnormalities caused by congenital defects, developmental abnormalities, trauma, tumors, infection or disease limited to covered dependents under age 18.
- Covered expenses are expanded to include:
  - Diagnosis and treatment of acquired brain injury, as specified in the certificate.
  - Up to $200 every five years for screening tests for atherosclerosis and abnormal artery structure and function, as defined in the certificate.
  - Habilitative services for an eligible child with congenital, genetic, or early acquired disorder.
  - One test for hearing loss within the first 30 days after birth and related necessary diagnostic follow up care during the first 24 months after birth. Deductible does not apply.
  - Diagnostic and surgical treatment of temporomandibular joint disorders (TMJ) and craniomandibular joint disorders.

Short Term Medical℠ State Variations, continued

Virginia

- Coverage term limited to 30-184 days.
- Short Term Medical℠ Plus Elite is not available.
- The reference to 24 months in the definition of preexisting conditions is changed to 12 months.
- Under Coordination of Benefits, the definition of plan will not include medical benefits under group or individual automobile contracts.

West Virginia

- Covered expenses for the treatment of Type I, Type II, or gestational diabetes are expanded to include the following medically necessary equipment and supplies: monitor supplies, injection aids, orthotics, and insulin infusion devices.
- Covered expenses for diabetes self-management training services are deleted and replaced with the following: Covered expenses for diabetes self-management training services are limited to $100 per covered person, per calendar year.
- When determining covered expenses for dental expenses, injury will include damage to the natural teeth incurred as a result of chewing if the damage was caused by a non-edible foreign object found in food.
- Covered expenses are expanded to include an annual kidney disease screening using any combination of blood pressure testing, urine albumin or urine protein testing as recommended by the National Kidney Foundation.
- Covered expenses are expanded to include charges for general anesthesia, facility fees, and other related charges incurred in conjunction with dental care (but not the actual dental services) that are provided in a hospital or an outpatient surgical facility to a covered person who:
  - Is an eligible child age 7 or under;
  - Is an eligible child age 12 or under with a documented phobia or mental disorder:
    - » Who has dental needs of such magnitude that treatment should not be delayed or deferred;
    - » When a lack of treatment can be expected to result in infection, loss of teeth, or other increased oral or dental morbidity; and
    - » When a successful result cannot be expected under local anesthesia because of such condition, but a superior result can be expected under general anesthesia;
  - Has a medical condition that requires hospitalization or general anesthesia for dental care;
  - Is developmentally disabled and successful results cannot be expected from dental care provided under local anesthesia due to the covered person's physical, intellectual or medically compromising condition; or
  - Has a chronic disability that:
    - » Can be attributed to a mental or physical impairment or a combination of mental and physical impairments;
    - » Is likely to continue; and
    - » Results in substantial functional limitations in one or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, capacity for independent living, or economic self-sufficiency.

Wisconsin

- A child called to active military duty prior to age 27 may be eligible after age 27 if a full-time student.
- Eligible children must be under 27 years of age at time of application. If age 26 at time of application, must also be unmarried.
- Home health aide services are limited to 40 home health care visits in a 12-month period. Specific details on Home Health Care Services are included in the certificate at issue.
- Kidney disease treatment is limited to dialysis, transplantation, and donor-related services. Maximum benefit is $30,000 per covered person annually.
- The spine and back limitation does not apply.
- Treatment of temporomandibular joint (TMJ) is covered. Non-surgical treatment is limited to $1,250 per calendar year. Specific details included in certificate at issue.
- Treatment for mental or nervous disorders, including substance abuse, will be covered the same as any other illness. Covered expenses will include transitional treatment arrangements for a covered person and outpatient counseling services for a member of the covered person's immediate family (spouse, children, parents, grandparents, or siblings) to enhance the treatment of the covered person.

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