



SHORT TERM MEDICAL

HEALTH INSURANCE PLANS | IN TIMES OF TRANSITION & CHANGE

States:
AZ FL IL IN
MS TX WI



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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, a UnitedHealthcare company, is the underwriter and administrator of these plans. See last page for more FACT details. This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your certificate carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your certificate might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

Certificate Forms C-016.2 and other state variations; Certificate Forms GRI-STAG19-C-EPO-42 and other state variations



UnitedHealthcare®
Golden Rule
Insurance Company

WHY SHORT TERM INSURANCE?

Short Term Medical plans are designed to give you access to health coverage for a limited time when, for whatever reason, employer or Affordable Care Act insurance isn't available to you.



BECAUSE LIFE MOVES FAST



You just graduated or retired early. You're between jobs. You missed open enrollment or are waiting for other coverage to start.

- **Apply for coverage any day of the year** – No qualifying event needed. No waiting for an enrollment period.
- **Complete a medical application** – Short Term Medical is medically underwritten. Application questions help determine if you're eligible for coverage.
- **Choose your plan duration from 1 month to just under 12 months**, depending on the state where you reside.
- **Pick your plan** – Four different Short Term Medical plans to choose from with many deductible options and a \$2 million lifetime maximum benefit per covered person (see pages 3-5).

BECAUSE LIFE CAN BE UNPREDICTABLE



Not having health insurance coverage for even a short amount of time can be expensive. What if you have an accident? What if you fall ill?

- **Coverage for doctor office visits, urgent care visits, emergency room, hospitalization, outpatient spine and back visits, limited preventive care and more**
- **Prescription coverage available on most of these plans**
- **Network access to quality care from 1.3 million physicians and health care professionals and 6,000 hospitals and medical facilities¹**
- **Use any doctor in the Choice network across the nation, no Primary Care Physician (PCP) required²**






¹ UnitedHealth Group Annual Form 10-K for year ended 12/31/18. ² There are no non-network benefits, except for emergencies (see page 6 for details).


This coverage does not qualify as "Minimum Essential Coverage" (MEC) as defined in the Affordable Care Act and may not cover all Essential Health Benefits in your state. And, while enforcement of the federal tax penalty is not occurring in 2019, some states may impose a tax penalty if you do not have MEC coverage. 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 certificate. It is important to note there are **State Variations, Exclusions and/or Limitations**, and **Plan Provisions**. This plan is medically underwritten. **No benefits will be paid for a health condition that exists prior to the date insurance takes effect.**



WHAT PLAN SHOULD YOU CHOOSE?

Different plans designed for almost any need or budget. Quality care at reduced costs because network providers agree to lower fees for covered expenses. **All plans have no application fees and no limit on the number of urgent care center visits with a copay.**

		Plus Elite	Copay	Plus	Value
 URGENT CARE COPAYS	✓	✓	✓	✓	✓
 DOCTOR OFFICE COPAY(S)			✓		
 OUTPATIENT PRESCRIPTIONS	✓	✓	✓		
 NO CHARGE AFTER DEDUCTIBLE	✓				
 LOWEST PREMIUM					✓



Plus Elite, a popular plan design, pays 100% of covered expenses after you meet the deductible. Keep coverage simple with no coinsurance.



KEEP YOUR
OUT-OF-POCKET COSTS
PREDICTABLE


Copay includes 1 to 4, \$75 copay, doctor office visits per person:

- No deductible to meet first.
- Number of available copay visits depends on the length of coverage.



MAKE THE DECISION TO
GO TO THE DOCTOR

Plus helps keep your after-deductible costs down. We pay 80%, you pay 20% of eligible expenses until the out-of-pocket maximum is reached. Then we pay 100% of eligible expenses.



KEEP YOUR
AFTER-DEDUCTIBLE COSTS
BALANCED

Value removes outpatient Rx coverage to provide a lower monthly premium compared to these other plans. If prescription costs aren't an issue for you, this plan might be a good fit.



KEEP YOUR
PREMIUM AS
LOW AS POSSIBLE

ALL PLANS:

CHOICE OF PLAN DURATION: 1-12 MONTHS (LESS ONE DAY)

See state variations for availability.

\$2 MILLION LIFETIME MAXIMUM BENEFIT

per covered person

NOT COVERED: NON-NETWORK EXPENSES

(except emergencies)
See page 6 for details.

OPTIONAL ACCIDENT BENEFIT

Additional premium required.
See page 7 for details.



HIGHLIGHTS OF SHORT TERM MEDICAL COVERED NETWORK EXPENSES

Plus Elite

COPAYS

\$25 PRESCRIPTIONS Tier 1¹
\$75 URGENT CARE VISITS

DEDUCTIBLE

Per person, per term
Choose one:
\$2,500 **\$10,000**
\$5,000 **\$12,500**
\$7,500

0% COINSURANCE – NO CHARGE AFTER DEDUCTIBLE

**YOU PAY NOTHING
AFTER DEDUCTIBLE**
No coinsurance on
Plus Elite plans

PRESCRIPTIONS Tiers 2-4¹
DOCTOR OFFICE VISITS
ER VISITS Additional \$500 deductible if not admitted
INPATIENT HOSPITAL, OUTPATIENT SURGERY, LABS & X-RAYS
PREVENTIVE CARE See page 9 for details and limitations



¹ You pay for Rx drugs at the point of sale at the lowest price available using the member ID card. There is a \$5,000 per person, per term covered expense maximum.

Copay

COPAYS

\$25 PRESCRIPTIONS Tier 1²
\$75 DOCTOR OFFICE VISITS³
\$75 URGENT CARE VISITS

DEDUCTIBLE

Per person, per term
Choose one:
\$2,500 **\$10,000**
\$5,000 **\$12,500**
\$7,500

THEN 20% COINSURANCE AFTER DEDUCTIBLE

Per person, per term
up to coinsurance
out-of-pocket maximum.
Choose one:
\$5,000 **\$10,000**

PRESCRIPTIONS Tiers 2-4²
ER VISITS Additional \$500 deductible if not admitted
INPATIENT HOSPITAL, OUTPATIENT SURGERY, LABS & X-RAYS
PREVENTIVE CARE See page 9 for details and limitations



² You pay for Rx drugs at the point of sale at the lowest price available using the member ID card. There is a \$5,000 per person, per term covered expense maximum.



³ Available number of doctor office visits for a copay varies by plan duration: 1-3 months = 1 visit, 4-6 months = 2 visits, 7-9 months = 3 visits, 10+ months = 4 visits. These copays are for injury or illness (history and exam) and cannot be used for preventive care, other than those required due to state mandates. Additional doctor office visits are covered using deductible then coinsurance.

ALL PLANS:

CHOICE OF PLAN DURATION: 1-12 MONTHS (LESS ONE DAY)

See state variations for availability.

\$2 MILLION LIFETIME MAXIMUM BENEFIT

per covered person

NOT COVERED: NON-NETWORK EXPENSES

(except emergencies)
See page 6 for details.

OPTIONAL ACCIDENT BENEFIT

Additional premium required.
See page 7 for details.



HIGHLIGHTS OF SHORT TERM MEDICAL COVERED NETWORK EXPENSES

Plus

COPAYS

\$25 PRESCRIPTIONS Tier 1¹
\$75 URGENT CARE VISITS

DEDUCTIBLE

Per person, per term
Choose one:
\$1,000 \$7,500
\$2,500 \$10,000
\$5,000 \$12,500

THEN 20% COINSURANCE AFTER DEDUCTIBLE

Per person, per term
up to coinsurance
out-of-pocket maximum.
Choose one:
\$2,000 \$10,000
\$5,000

▶ PRESCRIPTIONS Tiers 2-4¹

DOCTOR OFFICE VISITS

ER VISITS Additional \$500 deductible if not admitted

INPATIENT HOSPITAL, OUTPATIENT SURGERY, LABS & X-RAYS

PREVENTIVE CARE See page 9 for details and limitations



¹ You pay for Rx drugs at the point of sale at the lowest price available using the member ID card. There is a \$5,000 per person, per term covered expense maximum.

Value

COPAYS

\$75 URGENT CARE VISITS

DEDUCTIBLE

Per person, per term
Choose one:
\$2,500 \$10,000
\$5,000 \$12,500
\$7,500

THEN 30% COINSURANCE AFTER DEDUCTIBLE

Per person, per term
up to coinsurance
out-of-pocket maximum.
Choose one:
\$5,000 \$10,000

▶ INPATIENT PRESCRIPTIONS ONLY²

ER VISITS Additional \$500 deductible if not admitted

INPATIENT HOSPITAL, OUTPATIENT SURGERY, LABS & X-RAYS

PREVENTIVE CARE See page 9 for details and limitations



² Inpatient prescriptions (prescribed while admitted at a hospital) are still covered using deductible and coinsurance. To lower the premium of Value plans, prescriptions prescribed outside of a hospital are not covered — a discount card is provided. Discounts vary by pharmacy, geographic area, and Rx drug.

UNITEDHEALTHCARE CHOICE NETWORK

All of our plans use a network of doctors, hospitals, and other providers that offer you quality health care.



Visit UHOne.com and select [Find A Doctor](#) to search for network providers in your state.

NATIONWIDE NETWORK



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

ACCESS TO QUALITY CARE



- 1.3 million physicians and other health care professionals.*
 - More than 6,000 hospitals and other facilities.*
- * UnitedHealth Group Annual Form 10-K for year ended 12/31/18.

NETWORK-NEGOTIATED SAVINGS



Network providers agree to provide quality care at lower cost to you. There is no balance billing, meaning network providers will not charge you more than the network-negotiated rate.

NON-NETWORK (NOT COVERED)

There are no non-network benefits, except for emergencies.

- These plans pay benefits for eligible expenses from a network provider only.
- No benefits are payable for non-emergency care from a non-network provider.
- Emergency treatment from a non-network provider will be treated as a network eligible service. “Emergency” means an unforeseen or sudden medical condition manifesting itself by acute signs or symptoms which could reasonably result in death or serious disability if medical attention is not provided within 24 hours.



ROUND OUT YOUR COVERAGE



ACCIDENT ADD-ON

Reduce or eliminate your out-of-pocket exposure for accident-related injuries. This optional accident benefit helps cover your deductible or other medical expenses (before the health insurance starts paying covered expenses) for injuries resulting from an accident within 90 days. The benefit amount matches the Short Term Medical deductible selected and is per accident, per covered person.



Supplemental Benefit



TELEMEDICINE

Tired of waiting rooms and office copays? Save time and money with the convenience of virtual visits. The HealthiestYou app provides 24/7 access to a network of doctors ready to diagnose and prescribe treatment for many common illnesses right over the phone. You can also locate providers and shop around for the best prescription prices in your area. **Note: HealthiestYou is not insurance.**



HealthiestYou By Teladoc®



DENTAL & VISION

Consider coverage for those frequent family expenses with standalone Dental and Vision insurance. Dental plans help take care of your smile with benefits for services ranging from routine cleanings to root canals. Vision plans cover routine eye exams and can help pay for glasses, contacts or both. Note: Dental & Vision require separate applications, and separate policies are issued.



More Options

Additional payment is required for the above. The Supplemental Accident Benefit Rider (Form SA-S-1922G-GRI and state variations), and Dental and Vision products are underwritten by Golden Rule Insurance Company, a UnitedHealthcare company. HealthiestYou by Teladoc® and UnitedHealthcare are not affiliated and each entity is responsible for its own contractual and financial obligations. Product design and availability may vary by state. For costs, benefits, exclusions, limitations, eligibility, waiting periods and renewal terms, contact your broker.

MEDICAL BENEFITS

The following medical benefits are provided using network providers and are subject to all policy provisions, the deductible, and any applicable copay or coinsurance (unless otherwise stated). You will find complete coverage details in the policy/certificate. See State Variations for differences in the standard benefits below.

Ambulance Services

Ground ambulance service to a hospital for necessary emergency care. Air ambulance, with a maximum covered expense of \$5,000 per person, per policy term is covered if requested by police or medical authorities or if the covered person cannot be reached by ground ambulance.

Autism Spectrum Disorders

Outpatient applied behavior analysis limited to \$50,000 per term, per covered person.

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/certificate.**

Diabetes

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

Diagnostic Testing

Doctor Office Visit Copay (History and Exam)

Available with Copay plans only. Plan durations offered vary by state. Doctor office visit copays are for injury & illness and cannot be used for preventive care, other than those required due to state mandates.

Number of copay visits available varies by term's duration (see below).

Additional visits are subject to deductible then coinsurance.

<u>Plan duration</u>	<u># of copay visits</u>
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1-3 months	1
4-6 months	2
7-9 months	3
10+ months	4

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. Benefits for home health care will not extend beyond the term of your plan. Each 8-hour period of home health aide services will be counted as one visit. Private duty registered nurse services will be limited to a lifetime maximum of 1,000 hours. Intermittent private duty registered nurse visits are not to exceed 4 hours each and are limited to \$75 per visit (2 hours per visit are applied toward the lifetime maximum 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 inpatient; emergency treatment of an injury or illness. Covered expenses for use of the emergency room are subject to an additional \$500 deductible for each emergency room visit unless the covered person is directly admitted to the hospital for further treatment. **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.

Newborn Care

- For routine in-hospital newborn infant care expenses.
- Pregnancy not covered, except for complications.

MEDICAL BENEFITS, CONTINUED

Outpatient Surgery

Physician Fees

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

Prescriptions

- **Inpatient** (prescribed while admitted at a hospital): coverage available on all plans for deductible then coinsurance.
- **Outpatient** (prescribed outside of hospital): coverage **available with Plus Elite, Copay and Plus plans only**.
 - Each medication is placed in a tier, a numbered level. Tier 1: \$25 copay; Tiers 2-4: Deductible then coinsurance.
 - You pay for Rx drugs at the point of sale at the lowest price available using the member ID card. A \$5,000 per person, per term covered expense maximum is based on the total network-discounted cost for prescriptions—a combination of your share (whether the \$25 Tier 1 copay or your deductible/coinsurance) and the part paid by Golden Rule.

Preventive Care

Standard preventive care benefits in all states include one examination per covered person per term for each of the following:

- Routine mammography
- Cervical smear or pap smear
- Prostate specific antigen test (males 40 and over)

Additional preventive care benefits may be required in some states.

See state variations. Children's preventive health services for covered children as defined 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 term for both rehabilitation and ECF expenses.

Spine and Back Disorders

Benefits for treatment of spine and back disorders limited to \$2,500 per person, per term. This limitation does not apply to outpatient surgery.

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

Limitations apply. For a list of covered transplants, related covered expenses and services, see your certificate.

EXCLUSIONS & LIMITATIONS

This is only a general outline of the coverage provisions and exclusions. It is not an insurance contract, nor part of the insurance policy/certificate. You will find complete coverage details in the policy/certificate. Also see State Variations.

General Exclusions

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

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; (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; or (3) 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/certificate 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 or prevent conception or prevent childbirth.
- For artificial insemination or treatment for infertility or impotency.
- For sterilization or reversals of sterilization.
- For fetal reduction surgery or abortion (unless life of mother would be endangered).
- For treatment of malocclusions, disorders of the temporomandibular joint (TMJ) or craniomandibular disorders, except as expressly provided for by the policy/certificate.
- For modification of the physical body in order to improve psychological, mental, or emotional well-being, such as sex-change surgery.
- Not specifically provided for in the policy/certificate, including telephone consultations, failure to keep an appointment, television expenses, or telephone expenses.
- For marriage, family, or child counseling.
- For standby availability of a medical practitioner when no treatment is rendered.
- For hospital room and board and nursing services if admitted on a Friday or Saturday, unless for an emergency, or for medically necessary surgery that is scheduled for the next day.
- For dental expenses, including braces and oral surgery, except as provided for in the policy/certificate.
- 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.

EXCLUSIONS & LIMITATIONS, CONTINUED

General Exclusions, continued

No benefits are payable for expenses:

- 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, or nursing services, except as provided for in the policy/certificate.
- For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or any exam or fitting related to these devices, except as provided for in the policy/certificate.
- Due to pregnancy (except complications), except as provided in the policy/certificate.
- For diagnostic testing while confined primarily for well-baby care, except as provided in the policy/certificate.
- For treatment of mental disorders or substance abuse including court-ordered treatment for programs, except as provided in the policy/certificate.
- For preventive care or prophylactic care, including routine physical examinations, premarital examinations, and educational programs, except as provided in the policy/certificate.
- Incurred outside of the U.S., except for emergency treatment.
- Resulting from declared or undeclared war; intentionally self-inflicted bodily harm (whether sane or insane); or participation in a riot or felony (whether or not charged).
- For or related to durable medical equipment or for its fitting, implantation, adjustment or removal or for complications therefrom, except as provided for in the policy/certificate.
- For outpatient prescription drugs, except as provided for in the policy/certificate.
- For surrogate parenting.
- For treatments of hyperhidrosis (excessive sweating).
- For alternative treatments, except as specifically covered by the policy/certificate, including: acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing, and other alternative treatments defined by the Office of Alternative Medicine of the National Institutes of Health.
- Resulting from or during employment for wage or profit, if covered or required to be covered by workers' compensation insurance under state or federal law. If you entered into a settlement that waives your right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply.
- Resulting from intoxication, as defined by state law where the illness or injury occurred, or while under the influence of illegal narcotics or controlled substances, unless administered or prescribed by a doctor.
- For joint replacement, unless related to an injury covered by the policy/certificate.
- For non-emergency treatment of tonsils, adenoids, hemorrhoids or hernia.
- For injuries sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: sports (professional, or semi-professional, or intercollegiate), parachute jumping, hang-gliding, racing or speed testing any motorized vehicle or conveyance, scuba/skin diving (when diving 60 or more feet in depth), skydiving, bungee jumping, or rodeo sports.
- For injuries sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following if the covered person is paid to participate or to instruct: operating or riding on a motorcycle, racing or speed testing any non-motorized vehicle or conveyance, horseback riding, rock or mountain climbing, or skiing.
- For injuries sustained while performing the duties of an aircraft crew member, including giving or receiving training on an aircraft.
- For vocational or recreational therapy, vocational rehabilitation, outpatient speech therapy, or occupational therapy, except as provided for in the policy/certificate.
- Resulting from experimental or investigational treatments, or unproven services.

PLAN PROVISIONS

Coordination of Benefits (including Medicare)

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

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

Dependents

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

Effective Date

Expenses for injuries and illness are eligible for coverage as of your plan’s effective date. Earliest effective date is one day after application submission.

Eligibility

At time of application, the primary insured must be a minimum of 19 years of age.

Eligible Expense

An eligible expense means a covered expense as follows:

- **For Network Providers:** The contracted fee for the provider.
- **For Non-Network Providers:** As defined in the policy/certificate.

Emergency

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

No Non-Network Benefits

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

Non-Renewable

Your Short Term Medical certificate is not renewable. 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.

Termination

The policy/certificate will terminate on the earliest of:

- The insured’s 65th birthday.
- The primary insured’s death. If the policy/certificate includes dependents, it may be continued after the primary insured’s death by a spouse, if a covered person; otherwise, by the youngest child who is a covered person.
- Nonpayment of premiums when due.
- The termination date shown on the Data Page of the policy/certificate.
- The last day for which premium has been paid, following your request to terminate the policy/certificate.
- The date there is fraud or material misrepresentation made by or with the knowledge of a covered person filing a claim for benefits.

STATE VARIATIONS

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

Arizona

Certificate Form GRI-STAG16-C-EPO-02

- Plan duration: 1 to 12 months (less one day).
- An optional benefit is available during the initial application to apply for a second plan. This would provide a continuous, uninterrupted period of coverage for the two plans when applied for together. Continuous, uninterrupted period of coverage means a period of coverage beginning when your first plan with us becomes effective and continues without a gap in coverage to the end of a second plan with us. Coverage with us before the first plan or after the second plan will not be considered a continuous, uninterrupted period of coverage.
 - A condition that began before the effective date of the first plan with us is subject to preexisting limitations.
 - A condition that began during the first plan term with us will not be a preexisting condition under the second plan term with us.
 - For each of the two plans, you must meet a plan deductible, coinsurance, and coinsurance out-of-pocket maximum.
 - The option for consecutive plans results in higher prices for your two plans.

Florida

Certificate Form C-016.2-09

- Plan duration: 1 to 12 months (less one day).
- An eligible child may remain a covered person 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.

Illinois

Certificate Form C-016.2-12

- Plan duration: 1 to 6 months.
- 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.

- “Spouse” means the person to whom you are legally married, or partners in a civil union, whom is either of the same or opposite sex. A partner in a civil union is entitled to the same rights and benefits under the policy/certificate as a spouse.
- Covered expenses are expanded to include:
 - Inpatient treatment of alcoholism.
 - One pap smear each calendar year.
 - 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 persons 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.
 - 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 policy/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.
 - Contraceptive services including: drugs, devices and products approved by the FDA. (Exempt from deductible, copayments, coinsurance, when provided by a network provider).

STATE VARIATIONS, CONTINUED

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

- 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/certificate.
- The definition of emergency is deleted and replaced with the following: “Emergency” means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following: (a) Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (b) Serious impairment to bodily functions; or (c) Serious dysfunction of any bodily organ or part.

• NOTICE: THE SHORT-TERM, LIMITED-DURATION INSURANCE BENEFITS UNDER THIS COVERAGE DO NOT MEET ALL FEDERAL REQUIREMENTS TO QUALIFY AS “MINIMUM ESSENTIAL COVERAGE” FOR HEALTH INSURANCE UNDER THE AFFORDABLE CARE ACT. THIS PLAN OF COVERAGE DOES NOT INCLUDE ALL ESSENTIAL HEALTH BENEFITS AS REQUIRED BY THE AFFORDABLE CARE ACT. PREEXISTING CONDITIONS ARE NOT COVERED UNDER THIS PLAN OF COVERAGE. BE SURE TO CHECK YOUR POLICY CAREFULLY TO MAKE SURE YOU UNDERSTAND WHAT THE POLICY DOES AND DOES NOT COVER. IF THIS COVERAGE EXPIRES OR YOU LOSE ELIGIBILITY FOR THIS COVERAGE, YOU MIGHT HAVE TO WAIT UNTIL THE NEXT OPEN ENROLLMENT PERIOD TO GET OTHER HEALTH INSURANCE COVERAGE. YOU MAY BE ABLE TO GET LONGER TERM INSURANCE THAT QUALIFIES AS “MINIMUM ESSENTIAL COVERAGE” FOR HEALTH INSURANCE UNDER THE AFFORDABLE CARE ACT NOW AND HELP TO PAY FOR IT AT WWW.HEALTHCARE.GOV.

Indiana

Certificate Form C-016.2-13

- Plan duration: 1 to 12 months (not to exceed 364 days).
- “Preexisting condition” means a condition for which the covered person received medical advice or treatment within the 12 months immediately preceding the date he or she became insured under the certificate.

Mississippi

Certificate Form C-016.2-23

- Plan duration: 1 to 12 months (less one day).
- Covered expenses do not include treatment of temporomandibular joint (TMJ) disorders.
- An optional benefit is available during the initial application to apply for a second plan. This would provide a continuous, uninterrupted period of coverage for the two plans when applied for together. Continuous, uninterrupted period of coverage means a period of coverage beginning when your first plan with us becomes effective and continues without a gap in coverage to the end of a second plan with us. Coverage with us before the first plan or after the second plan will not be considered a continuous, uninterrupted period of coverage.
 - A condition that began before the effective date of the first plan with us is subject to preexisting limitations.
 - A condition that began during the first plan term with us will not be a preexisting condition under the second plan term with us.
 - For each of the two plans, you must meet a plan deductible, coinsurance, and coinsurance out-of-pocket maximum.
 - The option for consecutive plans results in higher prices for your two plans.

STATE VARIATIONS, CONTINUED

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

Texas

Certificate Form GRI-STAG19-C-EPO-42

- Plan duration: 1 to 12 months (less one day).
- 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 certificate.
- If a designated Center of Excellence is not used, covered expenses for a listed transplant will be reduced by 25% after application of any deductible amounts coinsurance provisions or copayment amounts.
- An optional benefit is available during the initial application to apply for a second plan. This would provide a continuous, uninterrupted period of coverage for the two plans when applied for together. Continuous, uninterrupted period of coverage means a period of coverage beginning when your first plan with us becomes effective and continues without a gap in coverage to the end of a second plan with us. Coverage with us before the first plan or after the second plan will not be considered a continuous, uninterrupted period of coverage.
 - A condition that began before the effective date of the first plan with us is subject to preexisting limitations.
 - A condition that began during the first plan term with us will not be a preexisting condition under the second plan term with us.
 - For each of the two plans, you must meet a plan deductible, coinsurance, and coinsurance out-of-pocket maximum.
 - The option for consecutive plans results in higher prices for your two plans.

Wisconsin

Certificate Form C-016.2-48

- Plan duration: 1 to 12 months (less one day).
- Eligible children must be under 27 years of age at the time of application.
- The spine and back limitation does not apply.
- Treatment for mental or nervous disorders, including substance abuse, is covered the same as any other illness.
- 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. The maximum benefit shall be further limited to \$30,000 per covered person annually.
- Treatment of temporomandibular joint (TMJ) disorders is covered. Non-surgical treatment is limited to \$1,250 per calendar year. Specific details included in the certificate at issue.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

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

MEDICAL INFORMATION PRIVACY NOTICE (Effective January 1, 2019)

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

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

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

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

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

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

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

- **For Payment** of premiums due us, to determine your coverage and to process claims for health care services you receive including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.

- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might conduct or arrange for medical review, legal services, and auditing functions, including fraud and abuse detection or compliance programs. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.

- **To Provide Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services.
- **To Plan Sponsors.** If your coverage is through an employer group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with Federal law.
- **For Underwriting Purposes.** We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to contact you for appointment reminders with providers who provide medical care to you.

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

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

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

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

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by Federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under Federal law, without your written authorization. Once you give us authorization to release your health information, we

cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, call the phone number listed on your health plan ID card.

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

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

• **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. In addition, you may obtain a copy of this notice at our websites such as www.uhone.com, www.myuhone.com, www.uhone4me.com, www.myallsavers.com, or www.myallsaversconnect.com.

• **You have the right to be considered a protected person.** (New Mexico only)

A “protected person” is a victim of domestic abuse who also is either: (i) an applicant for insurance with us; (ii) a person who is or may be covered by our insurance; or (iii) someone who has a claim for benefits under our insurance.

Exercising Your Rights

• **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, you may contact a UnitedHealthOne Customer Call Center Representative. For Golden Rule members call us at 800-657-8205 (TTY 711). For All Savers members, call us at 1-800-291-2634 (TTY 711).

• **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed below.

• **Submitting a Written Request.** Mail to us your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record at the following address:

• Privacy Office, 7440 Woodland Drive, Indianapolis, IN 46278-1719

• **You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.** We will not take any action against you for filing a complaint.

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

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

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

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

FINANCIAL INFORMATION PRIVACY NOTICE (Effective January 1, 2019)

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

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

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

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

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

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

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

Questions About this Notice. If you have any questions about this notice, you may contact a UnitedHealthOne Customer Call Center Representative. For Golden Rule members call us at 1-800-657-8205 (TTY 711). For All Savers members, call us at 1-800-291-2634 (TTY 711). The Notice of Privacy Practices, effective January 1, 2019, is provided on behalf of All Savers Insurance Company; All Savers Life Insurance Company of California; Golden Rule Insurance Company; Oxford Health Insurance, Inc.; UnitedHealthcare Insurance Company; and UnitedHealthcare Life Insurance Company. To obtain an authorization to release your personal information to another party, please go to the appropriate website listed in this Notice.

WHO WE ARE.

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

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

Our plans offer easy-to-understand health insurance designed for individuals and families in times of transition and change.



Plans only available to members of FACT, the Federation of American Consumers and Travelers (see below). If you're not already a member, you can enroll with your Short Term Medical application to be eligible to apply for these plans.

What is FACT?

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

Is there a cost for joining FACT?

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

What are the basic FACT membership benefits?

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

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

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

Your Short Term Medical certificate is not renewable.

Short Term Medical is issued for a specific period of time. 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.

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