TRH HEALTH INSURANCE COMPANY

Home Office: P.O. Box 313, Columbia, TN 38402-0313, 1-877-874-8323

GENERAL INFORMATION

Thank you for your interest in applying for Medicare Supplement Insurance. Please read the following guidelines carefully to assist you in completing the application.

1. To apply for this Medicare Supplement Insurance, you must be:
    a. Age 65 or older and enrolled in Medicare Part A and Part B; or
    b. Under age 65 and enrolled in Medicare Part A and Part B due to a disability or End Stage Renal Disease.

2. Please check your application for accuracy and be sure to sign your first and last name beside any corrections. Prompt return of any additional documents requested will prevent unnecessary delays in the underwriting process.

3. If you have current coverage, do not cancel your current coverage until you have been issued your policy by us and upon review, agree to accept the premium, terms and conditions of the new policy.

4. If approved for coverage, you will be mailed a billing statement for the initial amount due. This billed amount must be paid by the due date. Once the billed amount has been paid, each monthly billing thereafter will be by automatic draft from your bank account. The automatic draft from your bank account will occur on or after the 1st day of each month.

5. TRHH Medicare Supplement Insurance is age-rated. Your premium will be based on your current age and will be adjusted annually with each birthday. In addition, overall general premium adjustments may be necessary. You will be notified by letter 30 days in advance of any premium adjustment.

6. Your Plan Identification Card ("ID card") and Policy should arrive within a few days of your initial billing. Please review both the ID card and the Policy carefully, as they contain important information about your coverage. If you find that you are not satisfied with your Policy for any reason, you may return it to us. If you send the Policy back to us within 30 days after you receive it, we will treat the Policy as if it had never been issued and return all of your payments, less any claims paid.

Please refer to Open Enrollment and Guaranteed Issue information on the back side of this page.

OPEN ENROLLMENT

You are eligible for open enrollment if you are applying within six (6) months of turning age 65 or obtaining Medicare Part B, whichever occurs last. If you are in your open enrollment period, have not had a break in coverage of 63 days or more and, at the time of application, can provide proof of prior continuous creditable coverage of at least six (6) months, the pre-existing condition waiting period will be waived. If your prior continuous creditable coverage is less than six (6) months, the pre-existing condition waiting period will be reduced by the number of months prior continuous creditable coverage existed.

GUARANTEED ISSUE

You may qualify for the guaranteed issue of Plans A, B, C, F or G if you apply within 63 days of losing other coverage and you:

- Are in a Medicare Advantage plan (also known as Medicare Part C) and the plan is leaving the Medicare program, discontinues plans in your area, or you move out of the Medicare Advantage plan's service area;
- Are in original Medicare (Medicare Part A and Part B) and have coverage through an employer group health plan (including retiree or COBRA coverage) or union-based group health plan that pays after Medicare pays, and the employer group health plan or union plan terminates;
- Joined a Medicare Advantage plan when you first became eligible for Medicare Part A at age 65 and within twelve (12) months of joining, you decide you want to switch to original Medicare;
- Dropped your Medicare Supplement Insurance to join a Medicare Advantage plan for the very first time, have been in the Medicare Advantage plan less than twelve (12) months, and want to switch back to original Medicare; or
- Are age 65 or older with Medicare and are disenrolled from Medicaid.

Documentation verifying your circumstances will be required.

Please Note:

There may be other circumstances that qualify you for the guaranteed issue provision. Please consult with our Home Office regarding your circumstances at 1-877-874-8323, 7 a.m. - 5 p.m., Central Time. If you are not eligible for guaranteed issue, a six (6) month pre-existing condition waiting period may apply if you are approved for coverage.

TRH HEALTH INSURANCE COMPANY

Home Office: P.O. Box 313, Columbia, TN 38402-0313, 1-877-874-8323

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE COVERAGE

PLEASE PRINT CLEARLY AND USE BLACK INK

County Office or FBHP Agent Use Only			
Subgroup	County Office	FBHP Agent	Requested Effective Date

Section 1 – Insured Person (Owner)

First Name		MI	Last Name

Date of Birth	Age	Gender	Social Security No.	Marital Status
		☐ Male ☐ Female		☐ Single ☐ Married

Mailing Address (please include your apartment or suite number)

City	County	State	Zip Code

Phone No. ( ) _____ - _____

Alternate No. ( ) _____ - _____

Email Address (by providing your email address, you agree to receive electronic communications from Farm Bureau Health Plans)

How did you hear about FHBP?

☐ Internet ☐ TV ☐ Phone Book ☐ Radio ☐ Mail Ad ☐ Billboard ☐ TN Farm Bureau ☐ Family/Friend

☐ Yes ☐ No	Are you an existing TN Farm Bureau member? If "No", please submit a TN Farm Bureau Membership Application and Agreement. If "Yes", please complete the following information: TN Farm Bureau membership is in the name of: _____ TN Farm Bureau Membership Number: _____

Section 2 – Medicare Supplement Insurance Plan Selection

Select Medicare Supplement Insurance plan (check one plan)

☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D ☐ Plan F ☐ Plan G ☐ Plan M ☐ Plan N

TRH HEALTH INS. CO.

Farm Bureau HEALTH PLANS Tennessee

First Name | MI | Last Name

Section 3 – Important Coverage Information

Please Read Carefully

1. You do not need more than one Medicare Supplement Insurance plan.

2. If you purchase this Medicare Supplement Insurance plan, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Insurance plan.

4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted, if requested, within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

5. If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy based on these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of Medicare Supplement Insurance, or that you had certain rights to buy such insurance, you may be guaranteed acceptance in one or more of the Medicare Supplement Insurance plans offered by TRHH. Please include a copy of the notice from your prior insurer with your application.

TRH HEALTH INS. CO.

Farm Bureau HEALTH PLANS Tennessee

First Name _____ MI _____ Last Name _____

Section 4 – General Questions

Please answer all questions to the best of your knowledge:

1. Did you turn age 65 in the last six (6) months?	☐ Yes ☐ No
2. Are you enrolled in Part A (Hospital) of Medicare?	☐ Yes ☐ No
3. Are you enrolled in Part B (Medical) of Medicare? (a) If **"Yes,"** what is the effective date? _____ (b) If "**No**," give your expected effective date _____	☐ Yes ☐ No
4. Please enter your name and ID number (with letter designation) as it appears on your Medicare card: Name_____ ID Number_____	
If you are not enrolled in Medicare Part A and Part B, you are not eligible to apply for this Medicare Supplement Insurance.	
5. Are you covered for medical assistance through the state Medicaid program? **Please Note:** If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.	☐ Yes ☐ No
(a) If "**Yes**," will Medicaid pay your premiums for this Medicare Supplement Insurance?	☐ Yes ☐ No
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	☐ Yes ☐ No

Section 5 – Other Coverage Information

1. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, a Medicare HMO or PPO)? If "**Yes**," fill in your start and end dates and answer the questions below. **Please Note:** Your original start date may not be the date on your current ID card with the other plan. If you are still covered under the plan, leave the "END DATE" blank. BEGIN DATE_____ END DATE OR EXPECTED END DATE_____	☐ Yes ☐ No
(a) If you are still covered under the above Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement Insurance?	☐ Yes ☐ No
(b) Was this your first time in this Medicare plan?	☐ Yes ☐ No
(c) Did you cancel Medicare Supplement Insurance to enroll in this Medicare plan?	☐ Yes ☐ No
2. Do you have other Medicare Supplement Insurance in force? If "**Yes**," answer the following question: (a) With what company? _____ (b) What Medicare Supplement Insurance plan do you have? _____ (c) Please provide the original effective date of the Medicare Supplement. _____	☐ Yes ☐ No
(d) Do you intend to replace your current Medicare Supplement Insurance with this plan?	☐ Yes ☐ No

TRH HEALTH INS. CO.

Farm Bureau HEALTH PLANS Tennessee

First Name _____ MI _____ Last Name _____

3. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? If "**Yes**," answer the following question: (a) With what company and what kind of policy? _____ (b) What are your dates of coverage under the other policy? BEGIN DATE _____ END DATE OR EXPECTED END DATE _____ **Please Note:** If policy is still active, provide the expected end date.	☐ Yes ☐ No
4. Do you intend to replace your current health care coverage with this Medicare Supplement Insurance?	☐ Yes ☐ No

Section 6 – Medical Questions

Please answer the following questions to the best of your knowledge.

If you are applying within six (6) months of turning age 65 or obtaining Medicare Part B, whichever occurs last, you do not have to answer these questions.

In the last five (5) years, have you been treated for any of the following medical conditions:

☐ Yes ☐ No	1. Heart Attack or Congestive Heart Failure?	If "Yes," when?
☐ Yes ☐ No	2. Cancer (Not Skin Cancer)?	If "Yes," when?
☐ Yes ☐ No	3. Stroke or Trans Ischemic Attack (TIA)?	If "Yes," when?
☐ Yes ☐ No	4. Kidney Failure or Disease?	If "Yes," when?
☐ Yes ☐ No	5. Diabetes?	If "Yes," when?
☐ Yes ☐ No	6. Parkinson's Disease?	If "Yes," when?
☐ Yes ☐ No	7. Multiple Sclerosis or Lou Gehrig's Disease (ALS)?	If "Yes," when?
☐ Yes ☐ No	8. Muscular Dystrophy?	If "Yes," when?

Please list any prescription drugs (print full medication name) you are currently taking:

TRH HEALTH INS. CO.

Farm Bureau HEALTH PLANS Tennessee

First Name | MI | Last Name

Section 7 – Acknowledgements and Agreements

Please Read Carefully.

I understand and acknowledge:

TRH Health Insurance Company ("TRHH") is entitled to rely solely on the statements made on this application to be complete and correct to the best of my knowledge and belief.

I understand and acknowledge that the Medicare Supplement Insurance plan which may be issued:

- Will be effective, subject to all the terms and conditions of the Policy, upon approval of my application by TRHH; the effective date will be indicated with my ID card and in my Policy.
- Shall be binding only if each statement included on the application is complete and true to the best of my knowledge.

I understand and acknowledge the following:

- If my application is not submitted during an open enrollment period or guaranteed issue period, TRHH has the right to reject my application and any premiums paid will be refunded.
- I understand that this Medicare Supplement Insurance will not pay for benefits for hospital confinement beginning or medical expenses incurred during the first six (6) months of coverage if they are due to conditions for which medical advice was given or treatment recommended by a physician within six (6) months prior to the effective date of my Policy. Coverage is not limited if I satisfy creditable coverage requirements.
- I have received an Outline of Coverage. I understand that the "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" publication will be provided with my Policy.
- I have the right to examine the Policy. If I find that I am not satisfied with the Policy, I may return it to TRHH. If I send the Policy back to TRHH within 30 days after I receive it, TRHH will treat the Policy as if it had never been issued and return all of my payments to me less any claims paid.
- Premium for my Policy will be based on my current age and will be adjusted annually with each birthday.

TRH HEALTH INS. CO.

Farm Bureau HEALTH PLANS Tennessee

First Name MI Last Name

Section 7 – Acknowledgements and Agreements (Continued)

I authorize any doctor, hospital, clinic, provider of health care, insurance or reinsurance company, or any other person or firm having any information necessary to determine my eligibility for coverage, to give all such information to TRHH. I (or my personal representative) may request a copy of this authorization.

I understand the information in this application and any information obtained with this authorization will be used by TRHH to determine eligibility for coverage and that coverage will be affected by this information. I understand that this authorization is valid for 24 months.

I declare that all the foregoing statements provided by me in this application in its entirety are true, correct and complete to the best of my knowledge and belief.

I, the undersigned applicant, certify that I have read, or have had read to me, this completed application and that I realize that any false statement or misrepresentation in this application may result in voidance of my Policy.

If your age has been misstated in the application, we will adjust the premium to reflect the amount that should have been paid based on your correct age. If your age has been misstated in the application and, if based on your correct age this Medicare Supplement Insurance plan would not have been issued, we will refund the premium paid, less the amount of any claims paid, and the Policy will be considered never to have been issued.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Applicant Signature: _____ Date: _____

This application is not acceptable unless completely filled out and signed. A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.

Please send one signed and dated copy of this application to our Home Office at P.O. Box 313, Columbia, TN 38402-0313. Retain one signed and dated copy of this application for your records.

If you would prefer to email a scanned version of the application and applicable forms, please contact our Home Office for assistance at 1-877-874-8323.

Bank Draft Authorization Form

Farm Bureau Health Plans
PO Box 313
Columbia, TN 38402-0313
Phone: 877-874-8323
Billing Fax: 931-560-4278
billingmfp@fbhealthplans.com

County Office or FBHP Agent Use Only

Subgroup	County	Branch

General Information

- All requested information below is required to authorize your automatic bank draft.
- Upon completion, please submit to address, fax or email above.
- For bank changes, the form must be received at FBHP by the 20th of the month to be effective the first of the following month.
- Federal law prohibits an employer from making payment for a Medicare Supplement Plan for an active employee.
- **Cancellation**- the Subscriber may cancel this coverage for any reason by giving ten (10) days written notice to Farm Bureau Health Plans. Coverage will remain in effect until the paid-to-date. See your contract for specific information regarding cancellations and cancellations due to death of Subscriber.

Applicant/Subscriber Information

First Name	MI	Last Name

Requested Date of Change	Health Plan Subscriber ID Number	Dental Plan Subscriber ID Number

Banking Information

Authorization Type ☐ New Applicant ☐ Existing Subscriber	Requested Date of Change (for existing Subscribers)

Please complete or attach voided check.

Account Type: ☐ Checking Account ☐ Savings Account

Name of Financial Institution

Address of Financial Institution

Routing Number	Account Number

Authorization

I hereby authorize Farm Bureau Health Plans to initiate debit entries from the account indicated below for the monthly payment of health and/or dental coverage. The depository named below is authorized to debit my account. I acknowledge I am authorized to sign this agreement on behalf of all covered individuals and signatories to the account. I understand I have the right to revoke this authorization by notifying Farm Bureau Health Plans in writing at least ten (10) days prior to the time payment is due. I further agree that should a debit be dishonored, whether with or without a cause and whether intentionally or inadvertently, Farm Bureau Health Plans shall have no liability whatsoever, even if such dishonor results in forfeiture of coverage.

Applicant/Subscriber Printed Name **(Must be completed and in the name of parent, step-parent or legal guardian of minor applicant)**		**Payor Printed Name**	
Applicant/Subscriber Signature	**Today's Date**	**Payor Signature**	**Today's Date**

A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

TRH HEALTH INSURANCE COMPANY

Home Office: P.O. Box 313, Columbia, TN 38402-0313, 1-877-874-8323

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by TRH Health Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY INSURANCE COMPANY

We have reviewed your current medical or health insurance coverage. To the best of our knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reasons (check one):

_____ Additional benefits.
_____ No change in benefits, but lower premiums.
_____ Fewer benefits and lower premiums.
_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
_____ Disenrollment from a Medicare Advantage plan. Please explain the reason for disenrollment:
_____
_____ Other (please specify): _____

(1) Note: If the insurance company of the Medicare Supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions that you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy, whereas a similar claim might have been payable under your present policy.

(2) State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

(3) If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

TRH HEALTH INSURANCE COMPANY

Applicant Signature _____ Date _____

FARM BUREAU HEALTH PLANS
PERSONAL REPRESENTATIVE DESIGNATION

You have the right to request that Farm Bureau Health Plans give another person access to your protected health information. To do so, please complete this form along with your signature and return it to the Privacy Office. You may revoke this designation at any time with written notice to Farm Bureau Health Plans.

MEMBER INFORMATION (REQUIRED) – PLEASE PRINT		
First Name:	MI:	Last Name:
Address:		City, State, Zip:
Date of Birth:	Social Security #:	Identification #:
Telephone:	E-mail Address:	

PERSONAL REPRESENTATIVE – PLEASE PRINT		
First Name:	MI:	Last Name:
Address:		City, State, Zip:
Date of Birth:	Telephone:	Relationship to Member:

ADDITIONAL REPRESENTATIVE (OPTIONAL) – PLEASE PRINT		
First Name:	MI:	Last Name:
Address:		City, State, Zip:
Date of Birth:	Telephone:	Relationship to Member:

ADDITIONAL REPRESENTATIVE (OPTIONAL) – PLEASE PRINT		
First Name:	MI:	Last Name:
Address:	City, State, Zip:	
Date of Birth:	Telephone:	Relationship to Member:

SIGNATURE (REQUIRED)

I request the person(s) named above be allowed access to my protected health information. I understand that I may revoke this designation at any time by submitting a written notice to Farm Bureau Health Plans.

Member Signature **Date**

If the member is a minor, the subscriber parent or guardian must sign. If the member is unable to sign because of a physical or mental condition, the person completing this form must sign below. Documentation of the condition should be submitted with this form. If you are signing with Power of Attorney, a complete copy of the Power of Attorney must accompany this form.

Signature of Parent/Guardian/POA **Relationship to Member** **Date**

In order to process this designation, this form must be complete and signed by the member. Incomplete forms will not be accepted. **Return this form to Farm Bureau Health Plans Privacy Office, PO Box 313, Columbia, TN 38402-0313.**

For questions, call the Privacy Office at 931-388-7872 ext. 2578

YOU ARE ENTITLED TO A COPY OF THIS REQUEST.

TRH Health Insurance Company
Checklist for applying for Medicare Supplement Insurance

The TRH Health Insurance Company ("TRHH") Medicare Supplement Insurance application is not acceptable unless completely filled out and signed and all applicable documents are submitted. The following checklist has been provided to assist you with the accuracy and completion of your application and the application process.

- ☐ Complete SECTION 1 with your current information.
- ☐ In SECTION 2, select the Medicare Supplement Insurance plan of your choice.
- ☐ In SECTION 4, answer ALL QUESTIONS "YES" or "NO," and provide all applicable information to these questions.
- ☐ In SECTION 5, answer ALL QUESTIONS "YES" or "NO," and provide all applicable information regarding other coverage you have.
- ☐ In SECTION 6, answer ALL HEALTH QUESTIONS, and list ALL medications you are currently taking.
- ☐ In SECTION 7, read carefully and be sure to sign and date the enrollment application.
- ☐ Complete all sections of the TRHH Bank Draft Authorization (including payor information).
- ☐ You must submit a copy of your Medicare card.
- ☐ If you so choose, you may complete and sign the Personal Representative Designation. Completion of the Personal Representative Designation is not required.

Once you have completed the above checklist and reviewed your application and applicable forms for accuracy, please mail the following information to our Home Office at P.O. Box 313, Columbia, TN 38402- 0313. If you would prefer to email a scanned version of the application and applicable forms, please contact our Home Office for assistance at 1-877-874-8323.

REQUIRED DOCUMENTS FOR SUBMISSION

- Completed application for Medicare Supplement Insurance
- Completed TRHH Bank Draft Authorization
- Copy of your Medicare card
- Copy of your completed Replacement Form

If you have any questions or need assistance, please contact our Home Office at 1-877-874-8323, 7 a.m. - 5 p.m., CST. You may also go to www.fbhealthplans.com for additional information.

REMINDER: Retain one signed and dated TRHH Medicare Supplement Insurance application and Replacement Form.

Farm Bureau Health Plans

NOTICE 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 AND KEEP ON FILE FOR REFERENCE.

LEGAL OBLIGATIONS

Tennessee Rural Health Improvement Association (Farm Bureau Health Plans or "FBHP") is required by law to maintain the privacy of all medical information within its organization; provide this notice of privacy practices to all members; inform members of its legal obligations; advise members of additional rights concerning their medical information; and to notify affected members following a breach of unsecured Protected Health Information ("PHI"). FBHP must follow the privacy practices contained in this notice from its **effective date of September 15, 2016**, and continue to do so until this notice is changed or replaced.

FBHP reserves the right to change its privacy practices and the terms of this notice at any time, provided applicable law permits the changes. Any changes made in these privacy practices will be effective for all medical information that is maintained including medical information created or received before the changes were made. All members will be notified of any changes by receiving a new notice of privacy practices.

You may request a copy of this notice of privacy practices at any time by contacting Ryan D. Brown, FBHP, Chief Compliance and Privacy Officer, P.O. Box 313, Columbia, TN 38402-0313.

AFFILIATED ENTITIES COVERED BY THIS NOTICE

This notice applies to the privacy practices of the following affiliated covered entities that may share your Protected Health Information as needed for the purposes of treatment, payment, and health care operations: Tennessee Rural Health Improvement Association ("FBHP") and its subsidiaries, TRH Health Insurance Company and RH Group Services, Inc.

USES AND DISCLOSURES OF MEDICAL INFORMATION

Your medical information may be used and disclosed for treatment, payment and health care operations. For example:

TREATMENT: Your medical information may be disclosed to a doctor or hospital that requests it to provide treatment to you or for disease and case management programs.

PAYMENT: Your medical information may be used or disclosed to pay claims for services which are covered under your health care coverage.

HEALTH CARE OPERATIONS: Your medical information may be used and disclosed to determine premiums, conduct quality assessment and improvement activities, to engage in care coordination or case management, to pursue Right of Recovery and Reimbursement/Subrogation, accreditation, conducting and arranging legal services, underwriting and rating, and for other administrative purposes.

AUTHORIZATIONS: You may provide written authorization to use your medical information or to disclose it to anyone for any purpose. You may revoke this authorization in writing at any time but this revocation will not affect any use or disclosure permitted by your authorization while it was in effect. FBHP cannot use or disclose your medical information for marketing purposes or make any disclosures of your medical information that could constitute a sale of Protected Health Information unless you give written authorization. If you authorize use or disclosure by FBHP of your medical information for marketing purposes, we must also disclose to you if FBHP receives payment for your medical information. In the following limited circumstances, FBHP may use or disclose your medical information to a family member, relative or close personal friend: insofar as relevant to that person's involvement with your care or payment for health care; or to notify a family member, your personal representative or other responsible person of your location,

general condition or death. Except as noted, unless you give written authorization, we cannot use or disclose your medical information, including psychotherapy notes, for any reason other than those described in this notice.

PERSONAL REPRESENTATIVE: Your medical information may be disclosed to you or a personal representative designated by you by completing a Personal Representative Form. A designated personal representative acting within the scope of his authority will be entitled to disclosure of your medical information as you would be. Subject to certain exceptions, we may treat the parent, guardian or other person acting in loco parentis of individuals and minors as personal representatives with respect to disclosure of medical information.

Your medical information may be disclosed without your authorization for the purposes or under the circumstances described below:

UNDERWRITING: Your medical information may be used and disclosed for underwriting, premium rating or other activities relating to the creation, renewal, or replacement of health care coverage or benefits. However, FBHP is prohibited from and cannot use or disclose your genetic medical information for underwriting purposes unless you apply for long term care coverage. If FBHP does not issue that health care coverage, your medical information will not be used or further disclosed for any purpose, except as required by law.

RESEARCH: Your medical information may be used or disclosed for research purposes provided that certain established measures to protect your privacy are in place.

HEALTH RELATED COMMUNICATIONS WITH YOU: Your medical information may be used to contact you with information about health-related benefits, services or treatment alternatives that may be of interest to you. Your medical information may be disclosed to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter, in person, or is for products or services of nominal value, you may opt-out of receiving further information by telling us.

AS REQUIRED BY LAW: Your medical information may be used or disclosed as required by state or federal law. For example, we will use and disclose your PHI to comply with workers' compensation laws, to public health authorities acting within their authority, and for law enforcement purposes. We will disclose your PHI when required by the Secretary of Health and Human Services and state regulatory authorities.

COURT OR ADMINISTRATIVE ORDER: Medical information may be disclosed in the course of judicial or administrative proceedings pursuant to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances.

MATTERS OF PUBLIC INTEREST: Medical information may be released to appropriate authorities under reasonable assumption that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. Medical information may be released to the extent necessary to avert a serious threat to your health or safety or to the health or safety of others. Medical information may be disclosed when necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody. Medical information may be disclosed for purposes of child abuse reporting.

MILITARY AUTHORITIES: Medical information of Armed Forces personnel may be disclosed to Military authorities under certain circumstances. Medical information may be disclosed to federal officials as required for lawful intelligence, counterintelligence, and other national security activities.

BUSINESS ASSOCIATES: From time to time we engage third parties to provide various services for us. Whenever an arrangement with such a third party involves the use or disclosure of your medical information, we will have a written contract with that third party designed to protect the privacy of your medical information. For example, we may share your information with business associates who process claims or conduct disease management programs on our behalf.

HEALTH PLAN SPONSORS: FBHP may disclose limited medical information to the sponsor of your health plan as follows: summary health information may be disclosed to the plan sponsor for the purpose of obtaining bids for coverage under the plan, or modifying or terminating the plan; information limited to whether you are enrolled or disenrolled from a health insurance issuer offered by the plan; and for administrative functions related to the plan provided the sponsor

makes certain certifications to us.

INDIVIDUAL RIGHTS

You have the following rights. To exercise these rights, you must make a written request on our standard form. To obtain the form, call the FBHP Privacy Office at 931-560-0041. Forms are also available at www.fbhealthplans.com.

ACCESS: You have the right to receive or review copies of your medical information, with limited exceptions. You may request a format other than photocopies, which will be used unless FBHP cannot practicably do so. Any request to obtain access to your medical information must be made in writing. You may obtain a form to request access by using the contact information at the end of this notice or you may send us a letter requesting access to the address located at the end of this notice. If you request copies, there may be a charge of $6.50 for staff time to copy and prepare paper copies of your medical information for transmittal to you, as well as postage costs if you want the copies mailed to you. If your PHI is maintained in an electronic health record ("EHR") you also have the right to request that an electronic copy be sent to you or to another individual or entity. The fee for providing an electronic copy may not be greater than our labor costs in responding to your request for such a copy, plus the cost of electronic media (*e.g.*, CD or USB drive) provided if you request an electronic copy on portable media. If you request an alternative format, the charge will be cost-based for providing your medical information in that format. For a more detailed explanation of the fee structure, please contact our office using the information at the end of this notice. FBHP requires advance payment before copying your medical information.

ACCOUNTING: You have the right to receive an accounting of the disclosures of your medical information made by FBHP or by a business associate of FBHP. This accounting will list each disclosure that was made of your medical information for any reason other than treatment, payment, health care operations, and other than disclosures made to you or as authorized by you, or certain other disclosures (e.g., for national security or law enforcement purposes). The accounting will cover each disclosure made for six years prior to the date on which the accounting was requested (unless you request a shorter period of time). This accounting will include the date the disclosure was made, the name of the person or entity the disclosure was made to, a description of the medical information disclosed, the reason for the disclosure, and certain other information. If you request an accounting more than once in a 12-month period, there may be a reasonable cost-based charge for responding to these additional requests. For a more detailed explanation of the fee structure, please contact our office using the information at the end of this notice.

DESIGNATION OF PERSONAL REPRESENTATIVE: You have the right to designate a family member, friend or other person as your personal representative to whom your medical information may be disclosed. You may obtain a form to designate a personal representative by using the contact information at the end of this notice.

RESTRICTIONS ON DISCLOSURES: You have the right to request restrictions on FBHP's use or disclosure of your medical information. Generally, FBHP is not required to agree to these additional requests. Any agreement to restrictions on the use and disclosure of your medical information must be in writing and signed by a person authorized to make such an agreement on behalf of FBHP; such restrictions shall not apply to disclosures made prior to granting the request for restrictions. FBHP will not be bound unless the agreement is so memorialized in writing. If FBHP agrees to the restriction, we may not use or disclose medical information in violation of the restriction except to disclose medical information to a health care provider to provide emergency treatment.

CONFIDENTIAL COMMUNICATIONS: You have the right to request confidential communications about your medical information by alternative means or alternative locations. You must inform FBHP that confidential communication by alternative means or to an alternative location is required to avoid endangering you. You must make your request in writing and you must state that the information could endanger you if it is not communicated by the alternative means or to the alternative location requested. FBHP must accommodate the request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under your health plan.

AMENDMENT: You have the right to request that FBHP amend your medical information. Your request must be in writing and it must explain why the information should be amended. If FBHP accepts the request, we will notify you the request is accepted. FBHP may deny your request if the medical information you seek to amend was not created by FBHP or for certain other reasons. If your request is denied, FBHP will provide a written explanation of the denial within 60

days. You may respond with a statement of disagreement to be appended to the information you wanted amended. If FBHP accepts your request to amend the information, FBHP will make reasonable efforts to inform others, including the people you name, of the amendment and to include the changes in any future disclosures of that information.

BREACH NOTIFICATION: You have the right to receive notice of a breach. We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breaches of unsecured Protected Health Information (PHI) as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the PHI unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:

- A brief description of the breach, including the date of the breach and the date of its discovery, if known;
- A description of the type of unsecured PHI involved in the breach;
- Steps you should take to protect yourself from potential harm resulting from the breach;
- A brief description of the actions we are taking to investigate the breach, mitigate losses, and protect against further breaches;
- Contact information, including a toll-free telephone number, e-mail address, web site, or postal address to permit you to ask questions or obtain additional information.

In the event the breach involves 10 or more patients whose contact information is out of date we will post a notice of the breach on the home page of our web site or in a major print or broadcast media. If the breach involves more than 500 individuals in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 individuals, we are required to immediately notify the Secretary of Health and Human Services. We also are required to submit an annual report to the Secretary of Health and Human Services of a breach that involves less than 500 individuals during the year and we will maintain a written log of breaches involving less than 500 patients.

If you receive this notice on the FBHP web site or by any other electronic means, you may request a written copy of this notice by using the contact information at the end of this notice.

COMPLAINTS, QUESTIONS AND CONCERNS

If you want more information concerning FBHP's privacy practices or you have questions or concerns, please contact our Privacy Office.

You may complain to us by using the contact information below if you are concerned that: (1) FBHP has violated your privacy rights; (2) you disagree with a decision made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical information; or (3) to request that FBHP communicate with you by alternative means or at alternative locations. You may also submit a written complaint to the U.S. Department of Health and Human Services. The address to file a complaint with the U.S. Department of Health and Human Services will be provided upon request.

FBHP supports your right to protect the privacy of your medical information. There will be no retaliation in any way if you choose to file a complaint with FBHP or with the U.S. Department of Health and Human Services.

Privacy Office
Farm Bureau Health Plans
P.O. Box 313, Columbia, TN 38402-0313
Phone (931) 560-0041
E-mail: privacyoffice@fbhealthplans.com

Tennessee Rural Health Improvement Association is a membership-based, not-for-profit organization which promotes the health of the rural people of Tennessee. Members can learn of the programs and services offered by FBHP at their local Farm Bureau office.

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