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 or F 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.
APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE COVERAGE

PLEASE PRINT CLEARLY AND USE BLACK INK

SECTION 1 - INSURED PERSON (OWNER)

First Name
MI
Last Name

FOR OFFICE USE ONLY

Street Address

Sub Group

City
County
State
Zip Code
County

Primary Phone No. ( ) ______-_______ Best time to call ______ AM/PM

Effective Date

Alternate Phone No. ( ) ______-_______ Best time to call ______ AM/PM

ID Number

Email Address (Optional)

Rating Action:

Social Security Number

Date of Birth (mm/dd/yyyy)

Date of Birth (mm/dd/yyyy)

Marital Status (Optional)

Gender

☐ Married ☐ Divorced
☐ Single ☐ Widowed
☐ Male ☐ Female

Are you an existing TN Farm Bureau member? If "No," please submit a TN Farm Bureau Membership Application and Agreement.

☐ Yes ☐ No

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

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 reinstated, 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 reinstated 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 reinstated 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 reinstated 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.

SECTION 4 - GENERAL QUESTIONS

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE:

Yes No
☐ ☐ 1. Did you turn age 65 in the last six (6) months?

Yes No
☐ ☐ 2. Are you enrolled in Part A (Hospital) of Medicare?

   (a) If "Yes," please enter your name, ID number (with letter designation) and effective date exactly as it appears on your Medicare card:

   Name________________________________  ID Number_______________________

   Effective Date_____/_____/_____

   (b) If "No," give your expected effective date_____/_____/_____

Yes No
☐ ☐ 3. Did you enroll in Medicare Part B in the last six (6) months?

   (a) If "Yes," what is the effective date? _____/_____/_____
If you are not enrolled in Medicare Part A and Part B, you are not eligible to apply for this Medicare Supplement Insurance.

Yes No 4. Are you covered for medical assistance through the state Medicaid program?

(Note to Applicant: 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?

SECTION 5 - OTHER COVERAGE INFORMATION

Yes No 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.

START DATE_____/_____/_____ 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?
### Section 5 - Personal Questions

**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? (If you are still covered under the policy, leave "END DATE" blank.)

START DATE _____/_____/______    END DATE _____/_____/______

**4.** Do you intend to replace your current health care coverage with this Medicare Supplement Insurance?

### 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:

<table>
<thead>
<tr>
<th>Yes No</th>
<th>Question</th>
<th>If &quot;Yes,&quot; when?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ ☐</td>
<td>1. Heart Attack or Congestive Heart Failure?</td>
<td></td>
</tr>
<tr>
<td>☐ ☐</td>
<td>2. Cancer (Not Skin Cancer)?</td>
<td></td>
</tr>
<tr>
<td>☐ ☐</td>
<td>3. Stroke or Trans Ischemic Attack (TIA)?</td>
<td></td>
</tr>
<tr>
<td>☐ ☐</td>
<td>4. Kidney Failure or Disease?</td>
<td></td>
</tr>
<tr>
<td>☐ ☐</td>
<td>5. Diabetes?</td>
<td></td>
</tr>
<tr>
<td>☐ ☐</td>
<td>6. Parkinson's Disease?</td>
<td></td>
</tr>
<tr>
<td>☐ ☐</td>
<td>7. Multiple Sclerosis or Lou Gehrig's Disease (ALS)?</td>
<td></td>
</tr>
<tr>
<td>☐ ☐</td>
<td>8. Muscular Dystrophy?</td>
<td></td>
</tr>
</tbody>
</table>

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

1. ____________________  2. ____________________  3. ____________________  4. ____________________
   5. ____________________  6. ____________________  7. ____________________  8. ____________________
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.

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.
INSTRUCTIONS FOR BANK DRAFT AUTHORIZATION FORM

The following must be completed to authorize your automatic bank draft after you pay the initial paper invoice. If you are changing bank account information, this form must be received in our office ten (10) days prior to the next scheduled draft date.

1. **Signature of Applicant/Subscriber** (Required) – Subscriber must sign and date that he/she agrees to the terms and conditions as set forth in the Bank Draft Authorization. The Bank Draft Authorization must be signed by parent or legal guardian if member is under age 19.

2. **Signature of Payor** (Required) and Print Payor Name (Required) – Payor (owner/signatory of account) must sign and print name.

3. **Applicant/Subscriber Name** (Print) – Subscriber must print name.

4. **Identification Number** – Subscriber’s TRHH identification number must be included.

5. Check “Health,” “Dental,” and/or “Prescription” box(es) that apply.

6. Check “Bank Change” box and write in effective date of change.

7. Check Account Type – “Checking” or “Savings”.

8. Attach voided check to bottom of form if bank account is checking. *Deposit slips will not be accepted*. If savings account, this form must be taken to your financial institution for completion, including signature and telephone number of authorized representative.

9. Mail completed form to **TRH Health Insurance Company, P.O. Box 313, Columbia, TN 38402-0313, or you may fax to (931) 560-4278, Attention: Billing Department.**

10. Verify receipt of mailed or faxed form by calling (931) 388-7872 or toll free (877) 874-8323 and request to speak to a Billing Department representative.

*Please note: Federal law prohibits an employer from making payment for a Medicare Supplement Plan for an active employee.*
I hereby authorize TRH Health Insurance Company ("TRHH") to initiate debit entries from the account identified below for the monthly payment of premium of health, dental, or prescription 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 further understand I have the right to revoke this authorization by notifying TRHH in writing at least ten (10) days prior to the time payment is due and my account is charged in order to give TRHH a reasonable opportunity to act upon it. I further agree that should a debit be dishonored, whether with or without cause and whether intentionally or inadvertently, TRHH shall have no liability whatsoever, even if such dishonor results in forfeiture of coverage.

Print Applicant/Subscriber Name (Required)  
Signature of Applicant/Subscriber (Required)  
(Must be signed by parent, step-parent or legal guardian of minor applicant)

Date  
County  
Subgroup  

TRHH ID Number-Health  
TRHH ID Number-Dental  
TRHH ID Number-Prescription

☐ Quartely to Bank Draft  
☐ New Application (effective date)  
☐ Transfer  
☐ Bank Change (effective date)

PLEASE READ CAREFULLY

For Checking Accounts: Attach voided check here (No Deposit Slips)
For Savings Account: Fill out requested information completely and accurately. (No Deposit Slips)

Name and Address of Financial Institution

Routing Number  
Account Number

Signature, Authorized Representative of Financial Institution  
Telephone Number

Cancellation - Applicant/Subscriber may cancel this Policy for any reason by giving ten (10) days written notice to TRH Health Insurance Company; such notice is to be sent to our Home Office. The Policy will remain in effect until the paid-to date. Please see your Policy for specific information regarding cancellations and cancellations due to death of Applicant/Subscriber.
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’s Signature____________________________________ Date____________________

TRHH-POST-LG-FL14-360
You have the right to request that TRH Health Insurance Company 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 TRHH Privacy Office. You may revoke this designation at any time with written notice to TRH Health Insurance Company.

**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 REPRESENTATIVES (OPTIONAL)**

**PERSONAL REPRESENTATIVE - 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 TRH Health Insurance Company.

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 TRH Privacy Office, P.O. Box 313, Columbia, TN 38402-0313.

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

YOU ARE ENTITLED TO A COPY OF THIS REQUEST.
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 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.trh.com for additional information.

**REMINDER:** Retain one signed and dated copy of the TRHH Medicare Supplement Insurance application and Replacement Form.
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

TRH Health Insurance Company (“TRHH”) 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”). TRHH must follow the privacy practices contained in this notice from its effective date of September 23, 2013, and continue to do so until this notice is changed or replaced.

TRHH 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, TRHH, Chief Compliance and Privacy Officer, P.O. Box 313, Columbia, TN 38402-0313.

USES AND DISCLOSURES OF MEDICAL INFORMATION

Your medical information may be used and disclosed for treatment, payment, health care operations and administration. 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. TRHH cannot use or disclose your genetic medical information for underwriting purposes unless you apply for long term care coverage.

ADMINISTRATION: Your medical information may be used or disclosed to your group health plan sponsor for purposes of plan administration such as statistics to explain premium costs or summaries of services utilized.

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. TRHH 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. We must also disclose to you if TRHH receives payment for your medical information. Unless you give written authorization, we cannot use or disclose your medical information, including psychotherapy notes, for any reason except those described in this notice.

PERSONAL REPRESENTATIVE: Your medical information may be disclosed to you or to a family member, friend or other person to the extent necessary to assist with your health care or with payment for your health care but only if you agree we may do so or if they have the legal right to act for you, as described in the Individual Rights section of this notice.

UNDERWRITING: Your medical information may be received for underwriting, premium rating or other activities relating to the creation, renewal, or replacement of health care coverage or benefits. If TRHH 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 or 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 in responding to court and administrative orders and subpoenas, and to comply with workers’ compensation laws. 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 response 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 PHI, we will have a written contract with that third party designed to protect the privacy of your PHI. For example, we may share your information with business associates who process claims or conduct disease management programs on our behalf.

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 Privacy Office at 931-388-7872. Forms are also available at www.trh.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 TRHH cannot practically 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 will be a charge of $.25 per page and $10 for staff time to review, copy and prepare your medical information, and postage 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. 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. TRHH 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 TRHH or by a business associate of TRHH. This accounting will list each disclosure that was made of your medical information for any reason other than treatment, payment, health care operations and certain other activities since April 14, 2003; however, if disclosures for purposes of treatment, payment, or health care operations were made through an EHR, you have the right to request an accounting for such disclosures made during the previous three years. 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. Your medical information may be disclosed to your personal representative to the extent necessary to help with your health care or with payment for your health care. 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 TRHH’s use or disclosure of your medical information. Generally TRHH is not required to agree to these additional requests. You also have the right to request a limit on the medical information we communicate about you to someone who is involved in your care or the payment for your care. 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 TRHH; such restrictions shall not apply to disclosures made prior to granting the request for restrictions. TRHH will not be bound unless the agreement is so memorialized in writing.

CONFIDENTIAL COMMUNICATIONS: You have the right to request confidential communications about your medical information by alternative means or alternative locations. You must inform TRHH 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. TRHH must accommodate the request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premium and pay claims under your health plan.

AMENDMENT: You have the right to request that TRHH amend your medical information. Your request must be in writing and it must explain why the information should be amended. TRHH may deny your request if the medical information you seek to amend was not created by TRHH or for certain other reasons. If your request is denied, TRHH will provide a written explanation of the denial. You may respond with a statement of disagreement to be appended to the information you wanted amended. If TRHH accepts your request to amend the information, TRHH 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 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 TRHH 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 TRHH’s privacy practices or you have questions or concerns, please contact our Privacy Office.

If you are concerned that: (1) TRHH 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; (3) to request that TRHH communicate with you by alternative means or at alternative locations, you may complain to us using the contact information below. 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.

TRHH 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 TRHH or with the U.S. Department of Health and Human Services.

Privacy Office  
TRH Health Insurance Company  
P.O. Box 313, Columbia, TN 38402-0313  
Phone (931) 388-7872  
E-mail: privacyoffice@trh.com

9/23/2013