

Application for Medicare Supplement Insurance

National Health Insurance Company
 PO Box 3450 · Salt Lake City, UT 84110-3450
 Toll-free telephone (866) 916-8816 · Fax (801) 812-8212
 New Business Conversion Reinstatement

Section A. Applicant Information			
First Name	Middle Name	Last Name	
Social Security Number	Medicare Claim Number	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of Birth ____/____/____ (mm/dd/yyyy)	Current Age	State and Country of Birth	
Residence Address	City	State	Zip Code
Mailing Address (if different)	City	State	Zip Code
Home Telephone Number	Mobile Telephone Number	Email Address	

Section B. Plan and Billing Information		
Plan Applied For: <input type="checkbox"/> Plan A <input type="checkbox"/> Plan F <input type="checkbox"/> Plan High F <input type="checkbox"/> Plan G <input type="checkbox"/> Plan N	Select Policy Premium Payment Option (check only one) Bank Draft (EFT): <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly <input type="checkbox"/> I Authorize Bank Draft Payments Direct Bill: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly	
Have you lived with any of the following people for the past 12 months and still live with them currently? Check all that apply:		<input type="checkbox"/> Legal Spouse <input type="checkbox"/> Domestic or Civil Union Partnership <input type="checkbox"/> 1 to 3 Other Adults Age 50 or Older
If so, list the name of the household resident(s): _____		
Application Fee: \$25 Initial Premium: \$ _____ Total Amount Submitted: \$ _____	Requested Policy Effective Date ____/____/____ (mm/dd/yyyy)	Draft Initial Premium on ____/____/____ (mm/dd/yyyy)
Bank Routing # (9 digits) _____	Bank Account # (do not include check #) _____	
Bank Name: _____		Name(s) of Depositor(s): _____
Account Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings		Select Bank Draft Day _____ (1 st - 28 th)
If paying premium by Bank Draft, please include a voided check. The first draft will occur on the date your application is approved by NHIC (unless specified otherwise). All Checks will be processed as EFT (Electronic Funds Transfer) from your bank.		

Section C. Medicare and Insurance Information

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 a Medicare Supplement insurance policy or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. **Please include a copy of the notice from your prior insurer with your application.**

Answer all questions to the best of your knowledge. Mark "YES" or "NO" with an "X" to the questions below.

1. Did you enroll in Medicare Part B within the past six months? Yes No
2. Did you turn age 65 within the past six months? Yes No

Medicare Part A Effective Date

____/____/____(mm/dd/yyyy)

Medicare Part B Effective Date

____/____/____(mm/dd/yyyy)

3. Are you applying during a guaranteed issue period? (NOTE: If "Yes," please **attach proof of eligibility.**) Yes No

4. Do you have another Medicare Supplement or Medicare Select insurance policy in force? Yes No

If yes:

(a) Name of Company _____ Plan ____ Effective Date ____/____/____(mm/dd/yyyy)

(b) Do you intend to replace your current Medicare Supplement policy with this policy? Yes No
(If yes, complete the Replacement Notice)

(c) Indicate termination date ____/____/____(mm/dd/yyyy)

5. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates:

If you are still covered under this plan, leave "END" blank.

Start ____/____/____(mm/dd/yyyy) End ____/____/____(mm/dd/yyyy)

(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? (If yes, complete the Replacement Notice.) Yes No

(b) Describe reason for termination _____

(c) Planned date of termination ____/____/____(mm/dd/yyyy)

(d) Was this your first time in this type of Medicare plan? Yes No

(e) Did you drop a Medicare Supplement or Medicare Select policy to enroll in this plan? Yes No

6. Have you had coverage under any other health insurance within the past 63 days? Yes No
(for example, an employer, union, or individual health plan)

If yes:

(a) Name of company and type of policy _____

(b) Start date ____/____/____(mm/dd/yyyy) End date ____/____/____(mm/dd/yyyy)

(c) Reason for termination _____

7. Are you covered for medical assistance through California's Medi-Cal program? Yes No
(Note to applicant: If you are participating in a "Medi-Cal Program" and have not yet met your "Share of Cost," please answer "No" to this question.)

(a) If yes, will Medi-Cal pay your premiums for this Medicare Supplement policy? Yes No

(b) If yes, do you receive any benefits from Medi-Cal **other than** payment toward your Medicare Part B premium? Yes No

8. Have you received a copy of the **Guide to Health Insurance for People with Medicare**, the **Outline of Coverage**, and the **Notice of Information Practices**? Yes No

Section D. Health Information**For applicants applying as an Open Enrollee or under Guarantee Issue rights, skip sections D, E and F.**

I certify that I will answer the following questions to the best of my knowledge.
 I also acknowledge that misrepresentations material to our acceptance could result in a denial of benefits and/or rescission of the policy.

Signature of Applicant: _____ **Date:** ____/____/____ (mm/dd/yyyy)

 When was the last time you used tobacco in any form, or used nicotine products including a patch, gum, or electronic cigarettes?
 Within past week
 Within past 3 months
 Within past 12 months
 More than 12 months ago
 Never

1. Height ____ ft ____ in Weight _____ lbs

 2. Have you been hospitalized two or more times within the last two years? Yes No Unsure

 3. Are you currently hospitalized, bedridden, living in a nursing or assisted living facility, receiving hospice or home health care, using a wheelchair or a motorized mobility aid? Yes No Unsure

4. Have you ever:	a. been advised by a medical professional to have surgery, medical tests, treatment or therapy that has not been performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
	b. been advised by a medical professional that surgery may be required within the next 12 months for cataract(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
	c. had an organ transplant or amputation caused by disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure

 5. Have you ever been diagnosed with, treated, or been given medical advice by a medical professional for diabetes? Yes No Unsure

If "Yes" to question #5 above:	a. Have you ever been diagnosed with retinopathy or neuropathy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
	b. What is your most recent A1C level? _____ <input type="checkbox"/> Unknown	

6. Within the past ten years, have you been diagnosed with, treated for, tested positive for, or been given medical advice by a member of the medical profession for:	a. emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
	b. COPD (chronic obstructive pulmonary disease)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
	c. any chronic respiratory disorder other than asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure

 7. Within the past two years, have you been treated with supplemental oxygen or a nebulizer for a pulmonary disorder including asthma? Yes No Unsure

8. Within the past ten years, have you been diagnosed with, treated for, tested positive for, or been given medical advice by a member of the medical profession for:	a. Parkinson's disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
	b. Alzheimer's disease, dementia, cognitive or brain disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
	c. ALS (amyotrophic lateral sclerosis) or multiple sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
	d. systemic lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
	e. myasthenia gravis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
	f. scleroderma	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
	g. muscular dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
	h. Acquired Immune Deficiency Syndrome (AIDS)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
	i. AIDS Related Complex (ARC)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
	j. Human Immunodeficiency Virus (HIV) infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure

9. Have you been diagnosed with, treated for, tested positive for, or been given medical advice by a member of the medical profession for:	Yes, within the past 2 years	Yes, within the past 2 to 5 years	Yes, more than 5 years ago	Unsure	No, never
a. internal cancer or melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. leukemia, Hodgkin's disease or any other lymphoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. chronic kidney disease or End Stage Renal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. cirrhosis or chronic hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. alcoholism or drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. major depression, bipolar or personality disorder, schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. mental or nervous disorder requiring psychiatric hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. heart attack or coronary artery disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. congestive heart failure or enlarged heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. heart valve surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. heart rhythm disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. stroke or transient ischemic attack (TIA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. carotid artery disease or peripheral vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. osteoporosis with one or more fractures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. crippling or disabling arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. joint replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section E. Medication Information

Within the past 12 months, how many total prescription medications have you taken or have you been advised to take by a member of the medical profession? _____

Provide all the details below.
(Use Section F if additional space is needed.)

Medication Name (as shown on label)	Date Originally Prescribed	Frequency & Dosage	Diagnosis/Reason
	____ / ____ mm yyyy		
	____ / ____ mm yyyy		
	____ / ____ mm yyyy		
	____ / ____ mm yyyy		
	____ / ____ mm yyyy		

California law prohibits an HIV test from being required or used by health insurance companies as a condition for obtaining health insurance coverage.

Section F. Additional Comments (if needed)

Section G. Disclosure, Acknowledgements, and Agreement

Disclosure:

1. You do not need more than one Medicare Supplement policy.
2. If you purchase this policy, 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 policy.
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 under 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 the 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).

Acknowledgments and Agreement:

I wish to apply for Medicare Supplement insurance coverage. I acknowledge that I have received or been given access to review: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

I HAVE READ AND FULLY UNDERSTAND the questions and my answers on this application. To the best of my knowledge and belief they are true and complete. I understand the Company may conduct a telephone interview with me regarding the answers. I understand and agree the policy applied for will not take effect until issued by the Company, and that the agent is not authorized to extend, waive or change any terms, conditions or provisions of the coverage.

Caution: If your answers on this application contain misrepresentations material to our acceptance for coverage, the Company has the right to deny benefits or rescind your coverage. In addition, you may be subject to a civil penalty of up to ten thousand dollars (\$10,000)

A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1800-434-0222), or by accessing the Department of Insurance's Internet Web site (www.insurance.ca.gov).

Applicant's Signature: _____

Signed at (City and State): _____ **Date:** ____/____/____ (mm/dd/yyyy)

Section H. Agent Statement

Type of Sale: Telephone In Person Internet Mail Other _____

Send Policy to: Agent Applicant

Yes No

State the name and relationship of any other person present when this Application was taken.

Name _____ Relationship to the Applicant _____

- 1. Did you review the Application for correctness and any omissions?
- 2. Did the Applicant review the Application for correctness and any omissions?
- 3. Are you related to the Applicant?
If Yes, provide relationship: _____

Listed below are all other health insurance policies I have (a) sold to the Applicant which are still in force; and (b) sold to the Applicant in the last 5 years which are no longer in force.

Company	Type of Policy	Effective Date	In Force
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

I certify: 1) I have accurately recorded the information supplied by the Applicant; 2) I have given the Applicant an **Outline of Coverage** for the policy being applied for, the **Guide to Health Insurance for People on Medicare**, and the **Notice of Information Practices**; and 3) I have reviewed the current health coverage of the Applicant and have completed the chart above, as applicable. I find that additional coverage of the type and amount applied for is appropriate for the Applicant's needs.

Agent Signature: _____ Date: ____/____/____ (mm/dd/yyyy)

Agent #1:

Name Printed: _____

Code: _____ Telephone Number: _____

Email: _____ Split %: _____

Agent #2:

Name Printed: _____

Code: _____ Telephone Number: _____

Email: _____ Split %: _____

Health Information Authorization

This Authorization complies with the HIPAA Privacy Rule

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, or other health care provider that has provided services, treatment or payment to me, or on my behalf, within the past 10 years ("My Providers"), or consumer reporting agency, to disclose my entire medical record and any other protected health information concerning me to National Health Insurance Company ("NHIC") and its agents, employees and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes and excludes information related to genetic tests or genetic services (except to pay a claim related to such tests or services).

In addition I authorize MIB, Inc., and any MIB member insurer, to provide any medical or personal information that it has about me to NHIC, its reinsurer or any MIB-authorized third-party administrator performing underwriting services on NHIC's behalf. I also authorize NHIC, its reinsurer or authorized third-party administrator, to make a brief report of my personal health information to MIB, Inc.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

My protected health information is to be disclosed under this Authorization so that NHIC may: **1)** underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; **2)** obtain reinsurance; **3)** administer claims and determine or fulfill their responsibility for coverage and provision of benefits; **4)** administer coverage; and **5)** conduct other legally permissible activities that relate to any coverage I have or have applied for with NHIC.

For a period of 120 days from the date of this Authorization I authorize my NHIC Producer to receive certain protected health information about me that is related to an adverse underwriting decision or counteroffer for alternative coverage made during the underwriting of my application.

This Authorization shall remain in force for 30 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to: **NHIC at PO Box 3450, Salt Lake City, Utah 84110-3450, Attention: Privacy Officer.** I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that NHIC has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, NHIC may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

Name of Applicant (please print)

Signature of Applicant or Personal Representative

Date of Birth

Date

Description of Personal Representative's Authority or Relationship to Applicant (if applicable)

(Return to Company)

NATIONAL HEALTH INSURANCE COMPANY

Definition of Eligible Person for Guaranteed Issue

Guaranteed Issue for Eligible Persons Under the Balanced Budget Act of 1997: The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

- Enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits or the Medicare Part B 20% coinsurance for services to the individual (*eligible for Plans A, F, High Deductible F or N*); or
- Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual (*eligible for Plans A, F, High Deductible F or N*); or
- Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and premiums or copayments increase by 15% or more, benefits are reduced, or the provide contract is terminated with the medical provider treating the individual (*eligible for Plans A, F, High Deductible F or N*); or
- Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual (*eligible for Plans A, F, High Deductible F or N*); or
- Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, substantial violation of a material policy provision, or material misrepresentation (*eligible for Plans A, F, High Deductible F or N*); or
- Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then terminates coverage within 12 months of enrollment (*eligible for the same Plan you terminated with us, or, if that Plan is no longer available, Plans A, F, High Deductible F or N*); or
- Upon *first* becoming eligible for benefits under Part A at age 65, enrolls in a Medicare Advantage or PACE provider and then disenrolls within 12 months (*eligible for all plans available from us*); or
- Enrolled in a Medicare Part D Plan during the initial Part D enrollment period while enrolled under a Medicare Supplement policy that covers outpatient prescription drugs and terminate the Medicare Supplement policy (*eligible for Plans A, F, High Deductible F or N*).

Documentation of these events must be submitted with this Application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.

NATIONAL HEALTH INSURANCE COMPANY

Definition of Eligible Person for Open Enrollment

- A policy or certificate that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subdivision and who are 65 years of age or older.
- An issuer shall make available Medicare supplement benefit plans A, B, C, and F if currently available to an applicant who qualifies under this subdivision who is 64 years of age or younger and who does not have end-stage renal disease. An issuer shall also make available to those applicants Medicare supplement benefit plan K or L, if currently available, or Medicare supplement benefit plan M or N, if currently available. The selection between Medicare supplement plan K or L and the selection between Medicare supplement benefit plan M or N shall be made at the issuer's discretion.
- An individual enrolled in Medicare by reason of disability shall be entitled to open enrollment for six months after the date of enrollment in Medicare Part B, or if notified retroactively of eligibility for Medicare, for six months following notice of eligibility.
- An individual enrolled in Medicare Part B is entitled to open enrollment described for six months following receipt of a notice of termination or, if no notice is received, the effective date of termination from any employer sponsored health plan including an employer-sponsored retiree health plan, receipt of a notice of loss of eligibility due to the divorce or death of a spouse or, if no notice is received, the effective date of loss of eligibility due to the divorce or death of a spouse, from any employer-sponsored health plan including an employer-sponsored retiree health plan, or termination of health care services for a military retiree or the retiree's Medicare eligible spouse or dependent as a result of a military base closure or loss of access to health care services because the base no longer offers services or because the individual relocates.
- An individual enrolled in Medicare Part B is entitled to open enrollment if the individual was covered under a policy, certificate, or contract providing Medicare supplement coverage but that coverage terminated because the individual established residence at a location not served by the plan.
- An individual whose coverage was terminated by a Medicare Advantage plan shall be entitled to an additional 60-day open enrollment period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation, for any Medicare supplement coverage provided by Medicare supplement issuers and available on a guaranteed basis under state and federal law or regulation for persons terminated by their Medicare Advantage plan.
- An individual shall be entitled to an annual open enrollment period lasting 30 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement policy, that offers benefits equal to or lesser than those provided by the previous coverage.
- An individual enrolled in Medicare Part B is entitled to open enrollment upon being notified that, because of an increase in the individual's income or assets, they meet one of the following requirements: (1) they are no longer eligible for Medi-Cal benefits or (2) they are only eligible for Medi-Cal benefits with a share of cost and certifies at the time of application that they have not met the share of cost.

**National Health Insurance Company
Outline of Medicare Supplement Plans A, F, High Deductible F, G, N**

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A" Some plans may not be available in your state.

Basic Benefits:

Hospitalization - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end;

Medical Expenses - Part B coinsurance (generally 20% of Medicare-approved expenses) or co-payments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of the part B coinsurance or co-payments;

Blood - First three pints of blood each year;

Hospice - Part A coinsurance.

A❖	B	C	D	F❖	F❖*	G❖	K	L	M	N❖
Basic Including 100% Part B coinsurance	Basic Including 100% Part B coinsurance	Basic Including 100% Part B coinsurance	Basic Including 100% Part B coinsurance	Basic Including 100% Part B coinsurance	Basic Including 100% Part B coinsurance	Basic Including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 co-payment for office visits and up to \$50 co-payment for ER
	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
	Part B Deductible	Part B Deductible		Part B Deductible						
				Part B Excess (100%)	Part B Excess (100%)	Part B Excess (100%)				
	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-Pocket limit \$5560; paid at 100% after limit reached	Out-of-Pocket limit \$2780; paid at 100% after limit reached		

❖ Plans currently available for sale.

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$2300. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

**Premiums - Monthly Bank Draft
Non-Tobacco
Area 1 - 919-925, 931, 941-949
A one-time \$25 policy fee applies to each application**

Age	Plan A		Plan F		Plan HDF		Plan G		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-64	327.92	327.92	432.81	432.81	134.38	134.38	365.63	365.63	297.19	297.19
65	131.15	131.15	173.13	173.13	53.75	53.75	146.25	146.25	118.85	118.85
66	131.15	131.15	173.13	173.13	53.75	53.75	146.25	146.25	118.85	118.85
67	131.15	131.15	173.13	173.13	53.75	53.75	146.25	146.25	118.85	118.85
68	136.35	136.35	180.00	180.00	55.94	55.94	152.08	152.08	123.65	123.65
69	141.77	141.77	187.19	187.19	58.13	58.13	158.13	158.13	128.54	128.54
70	147.40	147.40	194.69	194.69	60.42	60.42	164.48	164.48	133.65	133.65
71	153.33	153.33	202.50	202.50	62.81	62.81	171.04	171.04	138.96	138.96
72	159.27	159.27	210.42	210.42	65.31	65.31	177.71	177.71	144.38	144.38
73	165.31	165.31	218.44	218.44	67.81	67.81	184.48	184.48	149.90	149.90
74	171.46	171.46	226.56	226.56	70.31	70.31	191.35	191.35	155.42	155.42
75	177.60	177.60	234.69	234.69	72.81	72.81	198.23	198.23	161.04	161.04
76	183.85	183.85	242.92	242.92	75.31	75.31	205.21	205.21	166.67	166.67
77	190.10	190.10	251.15	251.15	77.92	77.92	212.19	212.19	172.29	172.29
78	196.35	196.35	259.48	259.48	80.52	80.52	219.17	219.17	178.02	178.02
79	202.60	202.60	267.81	267.81	83.13	83.13	226.15	226.15	183.75	183.75
80	208.85	208.85	276.15	276.15	85.73	85.73	233.13	233.13	189.48	189.48
81	215.10	215.10	284.48	284.48	88.33	88.33	240.10	240.10	195.21	195.21
82	221.56	221.56	293.02	293.02	90.94	90.94	247.29	247.29	201.04	201.04
83	228.02	228.02	301.67	301.67	93.65	93.65	254.58	254.58	206.98	206.98
84	234.38	234.38	310.00	310.00	96.25	96.25	261.67	261.67	212.71	212.71
85	240.83	240.83	318.44	318.44	98.85	98.85	268.85	268.85	218.54	218.54
86	247.08	247.08	326.67	326.67	101.46	101.46	275.83	275.83	224.17	224.17
87	253.33	253.33	334.90	334.90	104.06	104.06	282.81	282.81	229.79	229.79
88	259.69	259.69	343.23	343.23	106.67	106.67	289.90	289.90	235.52	235.52
89	266.15	266.15	351.77	351.77	109.38	109.38	297.19	297.19	241.46	241.46
90	272.81	272.81	360.63	360.63	112.08	112.08	304.69	304.69	247.50	247.50
91	279.69	279.69	369.69	369.69	114.90	114.90	312.29	312.29	253.75	253.75
92	286.67	286.67	378.96	378.96	117.81	117.81	320.10	320.10	260.10	260.10
93	293.75	293.75	388.33	388.33	120.73	120.73	328.02	328.02	266.56	266.56
94	301.04	301.04	398.02	398.02	123.75	123.75	336.15	336.15	273.13	273.13
95	308.54	308.54	407.92	407.92	126.77	126.77	344.48	344.48	279.90	279.90
96	316.25	316.25	418.13	418.13	129.90	129.90	353.13	353.13	286.88	286.88
97	324.17	324.17	428.54	428.54	133.13	133.13	361.98	361.98	294.06	294.06
98	332.29	332.29	439.27	439.27	136.46	136.46	371.04	371.04	301.35	301.35
99	340.52	340.52	450.21	450.21	139.90	139.90	380.31	380.31	308.85	308.85

**Premiums - Monthly Bank Draft
Tobacco
Area 1 - 919-925, 931, 941-949
A one-time \$25 policy fee applies to each application**

Age	Plan A		Plan F		Plan HDF		Plan G		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-64	376.88	376.88	497.71	497.71	154.17	154.17	420.10	420.10	341.46	341.46
65	150.73	150.73	199.06	199.06	61.67	61.67	168.02	168.02	136.56	136.56
66	150.73	150.73	199.06	199.06	61.67	61.67	168.02	168.02	136.56	136.56
67	150.73	150.73	199.06	199.06	61.67	61.67	168.02	168.02	136.56	136.56
68	156.77	156.77	206.98	206.98	64.17	64.17	174.79	174.79	141.98	141.98
69	163.02	163.02	215.21	215.21	66.77	66.77	181.77	181.77	147.71	147.71
70	169.58	169.58	223.85	223.85	69.48	69.48	189.06	189.06	153.65	153.65
71	176.35	176.35	232.81	232.81	72.29	72.29	196.67	196.67	159.79	159.79
72	183.23	183.23	241.88	241.88	75.10	75.10	204.38	204.38	166.04	166.04
73	190.21	190.21	251.04	251.04	77.92	77.92	212.19	212.19	172.40	172.40
74	197.29	197.29	260.31	260.31	80.83	80.83	220.00	220.00	178.75	178.75
75	204.38	204.38	269.69	269.69	83.75	83.75	227.92	227.92	185.21	185.21
76	211.56	211.56	279.17	279.17	86.67	86.67	235.94	235.94	191.67	191.67
77	218.75	218.75	288.65	288.65	89.58	89.58	243.96	243.96	198.23	198.23
78	225.94	225.94	298.13	298.13	92.50	92.50	251.98	251.98	204.79	204.79
79	233.13	233.13	307.71	307.71	95.42	95.42	260.00	260.00	211.35	211.35
80	240.31	240.31	317.29	317.29	98.33	98.33	268.02	268.02	217.92	217.92
81	247.50	247.50	326.77	326.77	101.25	101.25	276.04	276.04	224.48	224.48
82	254.90	254.90	336.56	336.56	104.27	104.27	284.38	284.38	231.25	231.25
83	262.40	262.40	346.46	346.46	107.29	107.29	292.71	292.71	238.02	238.02
84	269.69	269.69	356.04	356.04	110.31	110.31	300.83	300.83	244.58	244.58
85	277.08	277.08	365.73	365.73	113.33	113.33	309.06	309.06	251.25	251.25
86	284.27	284.27	375.21	375.21	116.25	116.25	317.08	317.08	257.71	257.71
87	291.46	291.46	384.69	384.69	119.17	119.17	325.10	325.10	264.17	264.17
88	298.75	298.75	394.27	394.27	122.19	122.19	333.23	333.23	270.73	270.73
89	306.25	306.25	404.17	404.17	125.21	125.21	341.56	341.56	277.50	277.50
90	313.96	313.96	414.27	414.27	128.33	128.33	350.10	350.10	284.48	284.48
91	321.88	321.88	424.69	424.69	131.56	131.56	358.85	358.85	291.67	291.67
92	330.00	330.00	435.31	435.31	134.90	134.90	367.92	367.92	298.96	298.96
93	338.23	338.23	446.15	446.15	138.23	138.23	377.08	377.08	306.35	306.35
94	346.67	346.67	457.19	457.19	141.67	141.67	386.46	386.46	313.96	313.96
95	355.31	355.31	468.54	468.54	145.21	145.21	396.04	396.04	321.77	321.77
96	364.17	364.17	480.31	480.31	148.85	148.85	405.94	405.94	329.79	329.79
97	373.23	373.23	492.29	492.29	152.60	152.60	416.04	416.04	338.02	338.02
98	382.50	382.50	504.58	504.58	156.46	156.46	426.46	426.46	346.46	346.46
99	391.98	391.98	517.08	517.08	160.31	160.31	437.08	437.08	355.10	355.10

**Premiums - Monthly Bank Draft
Non-Tobacco
Area 2 - 900-918, 926-930
A one-time \$25 policy fee applies to each application**

Age	Plan A		Plan F		Plan HDF		Plan G		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-64	393.50	393.50	519.38	519.38	161.25	161.25	438.75	438.75	356.63	356.63
65	157.38	157.38	207.75	207.75	64.50	64.50	175.50	175.50	142.63	142.63
66	157.38	157.38	207.75	207.75	64.50	64.50	175.50	175.50	142.63	142.63
67	157.38	157.38	207.75	207.75	64.50	64.50	175.50	175.50	142.63	142.63
68	163.63	163.63	216.00	216.00	67.13	67.13	182.50	182.50	148.38	148.38
69	170.13	170.13	224.63	224.63	69.75	69.75	189.75	189.75	154.25	154.25
70	176.88	176.88	233.63	233.63	72.50	72.50	197.38	197.38	160.38	160.38
71	184.00	184.00	243.00	243.00	75.38	75.38	205.25	205.25	166.75	166.75
72	191.13	191.13	252.50	252.50	78.38	78.38	213.25	213.25	173.25	173.25
73	198.38	198.38	262.13	262.13	81.38	81.38	221.38	221.38	179.88	179.88
74	205.75	205.75	271.88	271.88	84.38	84.38	229.63	229.63	186.50	186.50
75	213.13	213.13	281.63	281.63	87.38	87.38	237.88	237.88	193.25	193.25
76	220.63	220.63	291.50	291.50	90.38	90.38	246.25	246.25	200.00	200.00
77	228.13	228.13	301.38	301.38	93.50	93.50	254.63	254.63	206.75	206.75
78	235.63	235.63	311.38	311.38	96.63	96.63	263.00	263.00	213.63	213.63
79	243.13	243.13	321.38	321.38	99.75	99.75	271.38	271.38	220.50	220.50
80	250.63	250.63	331.38	331.38	102.88	102.88	279.75	279.75	227.38	227.38
81	258.13	258.13	341.38	341.38	106.00	106.00	288.13	288.13	234.25	234.25
82	265.88	265.88	351.63	351.63	109.13	109.13	296.75	296.75	241.25	241.25
83	273.63	273.63	362.00	362.00	112.38	112.38	305.50	305.50	248.38	248.38
84	281.25	281.25	372.00	372.00	115.50	115.50	314.00	314.00	255.25	255.25
85	289.00	289.00	382.13	382.13	118.63	118.63	322.63	322.63	262.25	262.25
86	296.50	296.50	392.00	392.00	121.75	121.75	331.00	331.00	269.00	269.00
87	304.00	304.00	401.88	401.88	124.88	124.88	339.38	339.38	275.75	275.75
88	311.63	311.63	411.88	411.88	128.00	128.00	347.88	347.88	282.63	282.63
89	319.38	319.38	422.13	422.13	131.25	131.25	356.63	356.63	289.75	289.75
90	327.38	327.38	432.75	432.75	134.50	134.50	365.63	365.63	297.00	297.00
91	335.63	335.63	443.63	443.63	137.88	137.88	374.75	374.75	304.50	304.50
92	344.00	344.00	454.75	454.75	141.38	141.38	384.13	384.13	312.13	312.13
93	352.50	352.50	466.00	466.00	144.88	144.88	393.63	393.63	319.88	319.88
94	361.25	361.25	477.63	477.63	148.50	148.50	403.38	403.38	327.75	327.75
95	370.25	370.25	489.50	489.50	152.13	152.13	413.38	413.38	335.88	335.88
96	379.50	379.50	501.75	501.75	155.88	155.88	423.75	423.75	344.25	344.25
97	389.00	389.00	514.25	514.25	159.75	159.75	434.38	434.38	352.88	352.88
98	398.75	398.75	527.13	527.13	163.75	163.75	445.25	445.25	361.63	361.63
99	408.63	408.63	540.25	540.25	167.88	167.88	456.38	456.38	370.63	370.63

**Premiums - Monthly Bank Draft
Tobacco
Area 2 - 900-918, 926-930
A one-time \$25 policy fee applies to each application**

Age	Plan A		Plan F		Plan HDF		Plan G		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-64	452.25	452.25	597.25	597.25	185.00	185.00	504.13	504.13	409.75	409.75
65	180.88	180.88	238.88	238.88	74.00	74.00	201.63	201.63	163.88	163.88
66	180.88	180.88	238.88	238.88	74.00	74.00	201.63	201.63	163.88	163.88
67	180.88	180.88	238.88	238.88	74.00	74.00	201.63	201.63	163.88	163.88
68	188.13	188.13	248.38	248.38	77.00	77.00	209.75	209.75	170.38	170.38
69	195.63	195.63	258.25	258.25	80.13	80.13	218.13	218.13	177.25	177.25
70	203.50	203.50	268.63	268.63	83.38	83.38	226.88	226.88	184.38	184.38
71	211.63	211.63	279.38	279.38	86.75	86.75	236.00	236.00	191.75	191.75
72	219.88	219.88	290.25	290.25	90.13	90.13	245.25	245.25	199.25	199.25
73	228.25	228.25	301.25	301.25	93.50	93.50	254.63	254.63	206.88	206.88
74	236.75	236.75	312.38	312.38	97.00	97.00	264.00	264.00	214.50	214.50
75	245.25	245.25	323.63	323.63	100.50	100.50	273.50	273.50	222.25	222.25
76	253.88	253.88	335.00	335.00	104.00	104.00	283.13	283.13	230.00	230.00
77	262.50	262.50	346.38	346.38	107.50	107.50	292.75	292.75	237.88	237.88
78	271.13	271.13	357.75	357.75	111.00	111.00	302.38	302.38	245.75	245.75
79	279.75	279.75	369.25	369.25	114.50	114.50	312.00	312.00	253.63	253.63
80	288.38	288.38	380.75	380.75	118.00	118.00	321.63	321.63	261.50	261.50
81	297.00	297.00	392.13	392.13	121.50	121.50	331.25	331.25	269.38	269.38
82	305.88	305.88	403.88	403.88	125.13	125.13	341.25	341.25	277.50	277.50
83	314.88	314.88	415.75	415.75	128.75	128.75	351.25	351.25	285.63	285.63
84	323.63	323.63	427.25	427.25	132.38	132.38	361.00	361.00	293.50	293.50
85	332.50	332.50	438.88	438.88	136.00	136.00	370.88	370.88	301.50	301.50
86	341.13	341.13	450.25	450.25	139.50	139.50	380.50	380.50	309.25	309.25
87	349.75	349.75	461.63	461.63	143.00	143.00	390.13	390.13	317.00	317.00
88	358.50	358.50	473.13	473.13	146.63	146.63	399.88	399.88	324.88	324.88
89	367.50	367.50	485.00	485.00	150.25	150.25	409.88	409.88	333.00	333.00
90	376.75	376.75	497.13	497.13	154.00	154.00	420.13	420.13	341.38	341.38
91	386.25	386.25	509.63	509.63	157.88	157.88	430.63	430.63	350.00	350.00
92	396.00	396.00	522.38	522.38	161.88	161.88	441.50	441.50	358.75	358.75
93	405.88	405.88	535.38	535.38	165.88	165.88	452.50	452.50	367.63	367.63
94	416.00	416.00	548.63	548.63	170.00	170.00	463.75	463.75	376.75	376.75
95	426.38	426.38	562.25	562.25	174.25	174.25	475.25	475.25	386.13	386.13
96	437.00	437.00	576.38	576.38	178.63	178.63	487.13	487.13	395.75	395.75
97	447.88	447.88	590.75	590.75	183.13	183.13	499.25	499.25	405.63	405.63
98	459.00	459.00	605.50	605.50	187.75	187.75	511.75	511.75	415.75	415.75
99	470.38	470.38	620.50	620.50	192.38	192.38	524.50	524.50	426.13	426.13

**Premiums - Monthly Bank Draft
Non-Tobacco
Area 3 - All Other Zip Codes
A one-time \$25 policy fee applies to each application**

Age	Plan A		Plan F		Plan HDF		Plan G		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-64	301.68	301.68	398.19	398.19	123.63	123.63	336.38	336.38	273.41	273.41
65	120.65	120.65	159.28	159.28	49.45	49.45	134.55	134.55	109.35	109.35
66	120.65	120.65	159.28	159.28	49.45	49.45	134.55	134.55	109.35	109.35
67	120.65	120.65	159.28	159.28	49.45	49.45	134.55	134.55	109.35	109.35
68	125.45	125.45	165.60	165.60	51.46	51.46	139.92	139.92	113.75	113.75
69	130.43	130.43	172.21	172.21	53.48	53.48	145.48	145.48	118.26	118.26
70	135.60	135.60	179.11	179.11	55.58	55.58	151.32	151.32	122.95	122.95
71	141.07	141.07	186.30	186.30	57.79	57.79	157.36	157.36	127.84	127.84
72	146.53	146.53	193.58	193.58	60.09	60.09	163.49	163.49	132.83	132.83
73	152.09	152.09	200.96	200.96	62.39	62.39	169.72	169.72	137.90	137.90
74	157.74	157.74	208.44	208.44	64.69	64.69	176.05	176.05	142.98	142.98
75	163.40	163.40	215.91	215.91	66.99	66.99	182.37	182.37	148.16	148.16
76	169.15	169.15	223.48	223.48	69.29	69.29	188.79	188.79	153.33	153.33
77	174.90	174.90	231.05	231.05	71.68	71.68	195.21	195.21	158.51	158.51
78	180.65	180.65	238.72	238.72	74.08	74.08	201.63	201.63	163.78	163.78
79	186.40	186.40	246.39	246.39	76.48	76.48	208.05	208.05	169.05	169.05
80	192.15	192.15	254.05	254.05	78.87	78.87	214.48	214.48	174.32	174.32
81	197.90	197.90	261.72	261.72	81.27	81.27	220.90	220.90	179.59	179.59
82	203.84	203.84	269.58	269.58	83.66	83.66	227.51	227.51	184.96	184.96
83	209.78	209.78	277.53	277.53	86.15	86.15	234.22	234.22	190.42	190.42
84	215.63	215.63	285.20	285.20	88.55	88.55	240.73	240.73	195.69	195.69
85	221.57	221.57	292.96	292.96	90.95	90.95	247.35	247.35	201.06	201.06
86	227.32	227.32	300.53	300.53	93.34	93.34	253.77	253.77	206.23	206.23
87	233.07	233.07	308.10	308.10	95.74	95.74	260.19	260.19	211.41	211.41
88	238.91	238.91	315.77	315.77	98.13	98.13	266.70	266.70	216.68	216.68
89	244.85	244.85	323.63	323.63	100.63	100.63	273.41	273.41	222.14	222.14
90	250.99	250.99	331.78	331.78	103.12	103.12	280.31	280.31	227.70	227.70
91	257.31	257.31	340.11	340.11	105.70	105.70	287.31	287.31	233.45	233.45
92	263.73	263.73	348.64	348.64	108.39	108.39	294.50	294.50	239.30	239.30
93	270.25	270.25	357.27	357.27	111.07	111.07	301.78	301.78	245.24	245.24
94	276.96	276.96	366.18	366.18	113.85	113.85	309.25	309.25	251.28	251.28
95	283.86	283.86	375.28	375.28	116.63	116.63	316.92	316.92	257.50	257.50
96	290.95	290.95	384.68	384.68	119.50	119.50	324.88	324.88	263.93	263.93
97	298.23	298.23	394.26	394.26	122.48	122.48	333.02	333.02	270.54	270.54
98	305.71	305.71	404.13	404.13	125.54	125.54	341.36	341.36	277.25	277.25
99	313.28	313.28	414.19	414.19	128.70	128.70	349.89	349.89	284.15	284.15

**Premiums - Monthly Bank Draft
Tobacco
Area 3 - All Other Zip Codes
A one-time \$25 policy fee applies to each application**

Age	Plan A		Plan F		Plan HDF		Plan G		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-64	346.73	346.73	457.89	457.89	141.83	141.83	386.50	386.50	314.14	314.14
65	138.67	138.67	183.14	183.14	56.73	56.73	154.58	154.58	125.64	125.64
66	138.67	138.67	183.14	183.14	56.73	56.73	154.58	154.58	125.64	125.64
67	138.67	138.67	183.14	183.14	56.73	56.73	154.58	154.58	125.64	125.64
68	144.23	144.23	190.42	190.42	59.03	59.03	160.81	160.81	130.62	130.62
69	149.98	149.98	197.99	197.99	61.43	61.43	167.23	167.23	135.89	135.89
70	156.02	156.02	205.95	205.95	63.92	63.92	173.94	173.94	141.35	141.35
71	162.25	162.25	214.19	214.19	66.51	66.51	180.93	180.93	147.01	147.01
72	168.57	168.57	222.53	222.53	69.10	69.10	188.03	188.03	152.76	152.76
73	174.99	174.99	230.96	230.96	71.68	71.68	195.21	195.21	158.60	158.60
74	181.51	181.51	239.49	239.49	74.37	74.37	202.40	202.40	164.45	164.45
75	188.03	188.03	248.11	248.11	77.05	77.05	209.68	209.68	170.39	170.39
76	194.64	194.64	256.83	256.83	79.73	79.73	217.06	217.06	176.33	176.33
77	201.25	201.25	265.55	265.55	82.42	82.42	224.44	224.44	182.37	182.37
78	207.86	207.86	274.28	274.28	85.10	85.10	231.82	231.82	188.41	188.41
79	214.48	214.48	283.09	283.09	87.78	87.78	239.20	239.20	194.45	194.45
80	221.09	221.09	291.91	291.91	90.47	90.47	246.58	246.58	200.48	200.48
81	227.70	227.70	300.63	300.63	93.15	93.15	253.96	253.96	206.52	206.52
82	234.50	234.50	309.64	309.64	95.93	95.93	261.63	261.63	212.75	212.75
83	241.40	241.40	318.74	318.74	98.71	98.71	269.29	269.29	218.98	218.98
84	248.11	248.11	327.56	327.56	101.49	101.49	276.77	276.77	225.02	225.02
85	254.92	254.92	336.47	336.47	104.27	104.27	284.34	284.34	231.15	231.15
86	261.53	261.53	345.19	345.19	106.95	106.95	291.72	291.72	237.09	237.09
87	268.14	268.14	353.91	353.91	109.63	109.63	299.10	299.10	243.03	243.03
88	274.85	274.85	362.73	362.73	112.41	112.41	306.57	306.57	249.07	249.07
89	281.75	281.75	371.83	371.83	115.19	115.19	314.24	314.24	255.30	255.30
90	288.84	288.84	381.13	381.13	118.07	118.07	322.10	322.10	261.72	261.72
91	296.13	296.13	390.71	390.71	121.04	121.04	330.15	330.15	268.33	268.33
92	303.60	303.60	400.49	400.49	124.10	124.10	338.48	338.48	275.04	275.04
93	311.17	311.17	410.45	410.45	127.17	127.17	346.92	346.92	281.85	281.85
94	318.93	318.93	420.61	420.61	130.33	130.33	355.54	355.54	288.84	288.84
95	326.89	326.89	431.06	431.06	133.59	133.59	364.36	364.36	296.03	296.03
96	335.03	335.03	441.89	441.89	136.95	136.95	373.46	373.46	303.41	303.41
97	343.37	343.37	452.91	452.91	140.40	140.40	382.76	382.76	310.98	310.98
98	351.90	351.90	464.22	464.22	143.94	143.94	392.34	392.34	318.74	318.74
99	360.62	360.62	475.72	475.72	147.49	147.49	402.12	402.12	326.70	326.70

PREMIUM INFORMATION

We, National Health Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this State. We will not change the premiums for this policy during your first year of coverage. Thereafter your premium will increase each year based on your age at that time. No rate adjustment may be made on an individual basis. Also, your renewal premiums may change on a renewal date following the Effective Date of any change in the deductible and/or coinsurance amounts which you are required to pay under Medicare. Any such premium change will be based on the actuarial computations that we then use to determine the renewal premium.

DISCLOSURES

Use this outline to compare benefits and premiums among policies, certificates and contracts.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to us at: PO Box 3450, Salt Lake City, Utah 84110-3450. 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.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs. Neither National Health Insurance Company nor its agents are connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "The Medicare Handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLAN A
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1364	\$0	\$1364 (Part A deductible)
61st thru 90th day	All but \$341 a day	\$341 a day	\$0
91st day and after -While using 60 lifetime reserve days	All but \$682 a day	\$682 a day	\$0
Once lifetime reserve days are used:			
-Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
-Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$170.50 a day	\$0	Up to \$170.50 a day
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	\$0

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

PLAN A (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

*** Once you have been billed \$185 of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$185 of Medicare Approved Amounts **	\$0	\$0	\$185 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$185 of Medicare Approved Amounts**	\$0	\$0	\$185 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Part A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment First \$185 of Medicare Approved Amounts**	\$0	\$0	\$185 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**PLAN F and HIGH DEDUCTIBLE F
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1364	\$1364 (Part A deductible)	\$0
61st thru 90th day	All but \$341 a day	\$341 a day	\$0
91st day and after -While using 60 lifetime reserve days	All but \$682 a day	\$682 a day	\$0
Once lifetime reserve days are used:			
-Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
-Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$170.50 a day	Up to \$170.50 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	\$0

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN F and HIGH DEDUCTIBLE F (continued)
 MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR**

*** Once you have been billed \$185 of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT TREATMENT , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$185 of Medicare Approved Amounts ** Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$185 (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$185 of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$185 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
Part A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$185 of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$185 (Part B Deductible) 20%	\$0 \$0 \$0
Other Benefits - Not Covered by Medicare			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE , Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

**PLAN G
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1364	\$1364 (Part A deductible)	\$0
61st thru 90th day	All but \$341 a day	\$341 a day	\$0
91st day and after -While using 60 lifetime reserve days	All but \$682 a day	\$682 a day	\$0
Once lifetime reserve days are used:			
-Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
-Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$170.50 a day	Up to \$170.50 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	\$0

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G (continued)

MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

*** Once you have been billed \$185 of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT TREATMENT , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$185 of Medicare Approved Amounts ** Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$185 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$185 of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$185 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Part A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$185 of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$185 (Part B Deductible) \$0
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Other Benefits - Not Covered by Medicare

FOREIGN TRAVEL - NOT COVERED BY MEDICARE, Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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PLAN N
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1364	\$1364 (Part A deductible)	\$0
61st thru 90th day	All but \$341 a day	\$341 a day	\$0
91st day and after -While using 60 lifetime reserve days	All but \$682 a day	\$682 a day	\$0
Once lifetime reserve days are used:			
-Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
-Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$170.50 a day	Up to \$170.50 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	\$0

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N (continued)

MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

**** Once you have been billed \$185 of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$185 of Medicare Approved Amounts ** Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense	\$185 (Part B Deductible) Up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$185 of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$185 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
Part A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$185 of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$185 (Part B Deductible) \$0
Other Benefits - Not Covered by Medicare			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE, Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

National General
Notice of Privacy Practices for Protected Health Information

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.

The terms of this Notice of Privacy Practices apply to National Health Insurance Company, Integon National Insurance Company, Integon Indemnity Corporation, and Time Insurance Company. Your privacy and the protection of your health information are important to National General. Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 we are required to maintain the privacy of your protected health information (PHI) and to provide you with this notice regarding our duties and practices with respect to your protected health information.

Your Rights

Ask us to limit what we use or share

- You have the right to request your PHI not be used or disclosed for treatment, payment or healthcare operations. The request must be in writing to the National General Privacy Office at the address listed at the end of this notice. The request should include:
 - o The information you want restricted
 - o Whether the restriction is for use, disclosure or both
 - o To whom you want the restriction to apply
- National General is not required to agree to your request and we may say “no” if it would affect your care. You will be notified, in writing, if this is the case.

Request confidential communications

- You have the right to request that National General communicate with you in a specific way or to send mail to a different address. National General will consider any reasonable requests, and must say “yes” if you tell us you would be in danger if we do not. Your request should be sent in writing to the National General Privacy Office at the address listed at the end of this notice. The request should include:
 - o The alternate way or address that you want us to use when contacting you
 - o The reason for this alternate method of contact
- National General will contact you, in writing, if we are unable to grant your request

Get a copy of health and claims records

- You have the right to see and obtain a copy of your PHI contained in the designated record set.
- There may be a fee to copy and mail the requested information. You will be notified of the fee prior to incurring the charge. The designated record set at National General contains your application for insurance, copies of Explanations of Benefits for medical treatment, copies of bills submitted by providers, case management and utilization review information, and any medical record information received from providers and used in the underwriting or benefit analysis process.
- Under certain circumstances, National General may have the right to deny you access to your designated record set. You will be notified in writing if one of those circumstances exists at the time of your request. You may file an appeal with the National General Privacy Office at the address listed at the end of this notice if you are not satisfied with National General’s decision. The review of the appeal will be done by a licensed healthcare professional who did not participate in the original decision to deny, and National General will comply with the decision of the reviewer.

National General Notice of Privacy Practices for Protected Health Information

Ask National General to correct health and claims information

- You have the right to request an amendment to the PHI contained in the designated record set. You need to submit your request in writing to the National General Privacy Office at the address listed at the end of this notice. Please include the reason for requesting this change.
- National General may say “no” to your request, but we’ll tell you why in writing within 60 days. Get a list of those with whom we’ve shared information
- You have the right to request an accounting of the people or organizations National General has disclosed your PHI to for as far as six years prior to the date you ask.
- National General will include all disclosures except those about treatment, payment and health care operations. National General will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- The accounting will state the time of the disclosure, the purpose for which it was disclosed, and a description of the information disclosed.
- You need to send your written request to the National General Privacy Office at the address listed at the end of this notice.
- You may have additional rights available under your state’s laws and regulations

Get a copy of your privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. National General will provide you with a paper copy promptly by calling our Member Service department at 1- 888-781-0585. An electronic version is also available on National General’s website at www.nhic.com.

File a complaint if you feel your rights are violated

- You can complain if you feel National General has violated your rights by contacting us using the following contact information.

National General ATTN: Privacy Office
4455 LBJ Freeway, Suite 375
Dallas, TX 75244
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W. Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- National General will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choice about what National General may share. If you have a clear preference for how we share your information in the situation described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

National General Notice of Privacy Practices for Protected Health Information

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In the following cases we never share your information unless you give us your written permission:

- Marketing purposes
- Sale of your information

National General Uses and disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We also may use and disclose your information for underwriting health coverage. Although, outside of long term care insurance, we are prohibited from using or disclosing any genetic information for these underwriting purposes.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

National General Notice of Privacy Practices for Protected Health Information

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner, coroner, or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Abuse, Neglect or Domestic Violence Reporting.

To alert State or local authorities if we believe someone is a victim of child abuse or neglect or domestic violence.

Inmates.

If you are an inmate of a correctional facility or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official in order to provide you with medical services, protect you or others, or to ensure the safety of the correctional facility.

Fundraising.

To contact you for fundraising activities and you have the right to opt out of receiving such communications.

Use and Disclosures Requiring Authorization

Most uses and disclosures of psychotherapy notes require us to obtain an authorization. Finally, if your **PHI** is requested for a use or disclosure that requires your approval or authorization, you will be told why your information is requested, who is asking for the information, and what information is requested. Any time you provide us with a written authorization, you may revoke it any time in writing, to the extent that we have not already taken action in reliance on your previous authorization.

National General's Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We must let you know if a breach occurs that may have compromised the privacy or security of your information.

National General
Notice of Privacy Practices for Protected Health Information

- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

National General can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you.

Other Instructions

- Effective date of this notice is October 27, 2016
- You may review and print a copy of our most current Notice of Privacy Practices for Protected Health Information by visiting our Web site at www.nhic.com or you may request a hard copy by calling our Customer Service Department at 1-888-781-0585 or by emailing us at Privacy@nhic.com.
- Send all questions or requests, such as the ones detailed in this notice to:

National General
ATTN: Privacy Office
4455 LBJ Freeway, Suite 375
Dallas, TX 75244

MIB Information Notice

Information regarding your insurability will be treated as confidential. National General or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184- 8734.

National General, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

