Medicare Supplement Insurance
Application Transmittal Form

Please fill out the following fields:

Selling agent name

Selling agent number

Agent telephone

Agent email

Submitting Medicare Supplement applications to Allstate Health Solutions is easy. Here's how:

1. **Download the appropriate application.** Fill it out with your client.

2. **Submit the completed application.** There are 3 ways to submit paper Medicare Supplement Insurance applications. **MAKE SURE YOU INCLUDE THIS COVER LETTER, INCLUDING YOUR INFORMATION.**

    1. **Mail:**
    Allstate Health Solutions
    PO Box 95464
    Cleveland, OH 44101

    2. **Email (scanned apps):**
    Send to NPSMedicareSuppApps@NGIC.com
    Please be sure to send securely.

    3. **Fax:**
    (888) 344-3232

For status updates and/or confirmation of receipt, call Agent Services:
(888) 966-2345 (Monday-Friday, 7:00 a.m. - 4:00 p.m. Central Time).

Allstate Health Solutions is a marketing name for products underwritten by National Health Insurance Company.

Application for Medicare Supplement Insurance

National Health Insurance Company
PO Box 95464, Cleveland, OH 44101
Toll-free telephone: (888) 966-2345 • www.Allstatehealth.com • NPSMedicareSuppApps@ngic.com •Fax: (888) 344-3232

☐ New Business ☐ Conversion ☐ Reinstatement

Section A. Applicant Information

First Name	Middle Name	Last Name	
Social Security Number	Date of Birth ____/____/____ (mm/dd/yyyy)	☐ Male ☐ Female	
Residence Address	City	State	Zip Code
Mailing Address (if different)	City	State	Zip Code
Telephone Number ☐Home ☐Mobile ☐Work	Email Address		

I agree to receive my certificate and any other plan documents or correspondence electronically: ☐ Yes ☐ No

Section B. Plan Information

Did you first become eligible for Medicare due to age, disability or end-stage renal disease prior to January 1, 2020? ☐ Yes ☐ No

Plan Applied For:

☐ Plan A ☐ Plan F* ☐ Plan High F* ☐ Plan G ☐ Plan N

*Plan F and Plan High F only available to applicants eligible for Medicare prior to 2020.

Have you lived with any of the following people for the past 12 months and still live with them currently? ☐ Yes ☐ No

- Legal Spouse
- Domestic or Civil Union Partnership
- 1 to 3 Other Adults Age 50 or Older

If "Yes", list the name of the household resident(s): _____

Do they have or are they currently applying for a Medicare Supplement policy with National Health Insurance Company? ☐ Yes ☐ No

If Yes, what is the policy number _____

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 6 months? ☐ Yes ☐ No
2. Did you turn age 65 within the past 6 months? ☐ Yes ☐ No

Medicare Number	**Medicare Part A Effective Date**	**Medicare Part B Effective Date**
_____	____/____/____ (mm/dd/yyyy)	____/____/____ (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) Planned date of termination____/____/____ (mm/dd/yyyy)
   (c) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No
   (d) 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)

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 section D.

The information I provided on this enrollment form is complete, true and accurate to the best of my knowledge and belief. I realize that any incomplete, false, or inaccurate statement or material misrepresentation in the enrollment form may result in cancellation of my coverage, a change in my premium, or a rescission of my coverage.

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

For underwriting purposes provide the name and address of your primary care physician

Name: _____

Address: _____

Applicant's Height _____ft _____in Weight _____lbs

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 ☐ Unsure

Please read through each question carefully and indicate any of the conditions that apply with a check mark in the box. If any of the answers to questions 1-8 below are "Yes" coverage cannot be issued.

1. Have you been recommended or scheduled for testing (excluding routine), treatment, follow-up, or surgery that has not been completed? ☐ Yes ☐ No ☐ Unsure
2. Are you currently hospitalized, confined to a bed, receiving dialysis treatment, receiving services from an Assisted Living Facility, Nursing Home, or dependent on a wheelchair or mobilized device? ☐ Yes ☐ No ☐ Unsure
3. In the last 12 months have you received Physical, Occupation, or Speech Therapy? ☐ Yes ☐ No ☐ Unsure
4. Have you been hospitalized or used an emergency room for treatment 2 or more times in the past 24 months? ☐ Yes ☐ No ☐ Unsure
5. If you have you been diagnosed or treated for diabetes (answer no if you have not been diagnosed or treated for diabetes) ☐ Yes ☐ No ☐ Unsure
   - Are you currently prescribed 3 or more medications to control High Blood Pressure?
   - Have you been treated for any diabetic complications including nephropathy, retinopathy, peripheral vascular disease, stroke, neuropathy, or heart disease?

6. Within the past 2 years have you been diagnosed, treated, evaluated, or prescribed medication for? ☐ Yes ☐ No ☐ Unsure

Cancer

- □ Hodgkin's Disease
- □ Internal Cancer
- □ Leukemia, Myeloma or Lymphoma
- □ Melanoma

Cardiovascular

- □ Chronic Atrial Fibrillation
- □ Chest Pain (Angina)
- □ Coronary Artery Disease, Angioplasty, Stent, or Bypass
- □ Heart Attack/Acute MI

Circulatory

- □ Aneurysm
- □ Blood/clotting disorder (excluding mild anemia)
- □ Deep Venous Thrombosis
- □ Embolus
- □ Peripheral Vascular Disease
- □ Transient Ischemic Attack
- □ Stroke

Neurological

- □ Muscular Dystrophy
- □ Multiple Sclerosis
- □ Transverse Myelitis

Other

- □ Adrenal gland disorders
- □ Chronic Hepatitis or liver cirrhosis
- □ Cushing Syndrome/Disease
- □ Joint Replacement Surgery that has not been completed
- □ Osteoporosis with fractures
- □ Pulmonary disease (excluding asthma)
- □ Required use of a Cardiac Pacemaker or Defibrillator
- □ Spinal Stenosis
- □ Amputation due to disease
- □ Chronic Pancreatitis
- □ Enzyme disorders
- □ Nephritis or Glomerulonephritis
- □ Pituitary disease or disorder
- □ Renal Artery Stenosis including Stent/Angioplasty
- □ Oxygen or Nebulizer use
- □ Substance Abuse (including more than 12 consecutive months of opioid usage)

7. Within the past 12 months have you been recommended for surgery or are you receiving any infusions or injections for treatment of: ☐Yes ☐No ☐Unsure

- □ Arthritis of any kind
- □ Plaque Psoriasis
- □ Crohn's Disease
- □ Ulcerative Colitis

8. Within the past 10 years have you been diagnosed, treated, evaluated, or prescribed medication for? ☐Yes ☐No ☐Unsure

Cardiovascular

- □ Cardiomyopathy
- □ Congestive Heart Failure
- □ Enlarged Heart
- □ Heart Valve Disease or Regurgitation

Neurological

- □ ALS (Amyotrophic Lateral Sclerosis)
- □ Alzheimer's Disease
- □ Dementia
- □ Parkinson's Disease

Autoimmune Disorder

- □ AIDS Related Complex
- □ Myasthenia Gravis
- □ Systemic Lupus
- □ Systemic Scleroderma

Other

- □ Chronic Obstructive Pulmonary Disease
- □ Cirrhosis
- □ Emphysema
- □ Organ, Bone Marrow, Tissue, or Stem Cell Transplant
- □ Renal Failure or End Stage Renal Failure
- □ Schizophrenia

10. Please list any medications that have been prescribed in the past 18 months for you; Include pills, creams, injections, liquids, inhalers, pumps, etc.

Medication	Reason taken	Dose	Frequency	Still taking?
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No

Comments on medical conditions or medications-

_____

_____

_____

_____

Section E. 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 reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. If you are eligible for and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy 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 reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of 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).
7. **California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**

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 are incorrect or untrue, the Company has the right to deny benefits or rescind your coverage.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison, or any combination thereof.

Applicant's Signature: _____

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

Section F. Agent Statement

Type of Sale: ☐ Telephone ☐ In Person ☐ Internet ☐ Mail ☐ Other _____

Send Policy to ☐ Agent ☐ Applicant

Yes	No	
☐	☐	Did anyone assist the proposed insured in completing the application or answering the application questions?

Name _____

Relationship to the Applicant _____

Type of assistance provided _____

☐	☐	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
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ 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 Name: _____ Agent ID: _____

Allstate HEALTH SOLUTIONS

Billing Information

Application Fee: $ Initial Premium: $_____ Total Amount Submitted: $	Requested Policy Effective Date _____/_____/_____(mm/dd/yyyy)	Draft Initial Premium on _____/_____/_____(mm/dd/yyyy)

Note: Recurring draft date is the same day as the first effective date of the policy. If this day does not exist in a month, payment will be drafted on the next business day.

Select policy premium payment option (check only one):

1. Bank Draft
   - ➔ Select Account Type: ☐ Checking ☐ Savings
   - ➔ Select frequency: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual
   - ➔ To begin withdrawals:

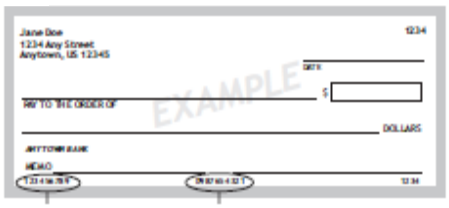
Name on Account:_____

Bank name:_____

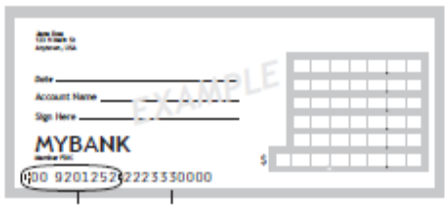
Routing number: __ __ __ __ __ __ __ __ __

Account number:_____

For paper application only: 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.



Routing Number 9 digits Account Number



Routing Number 9 digits Account Number

2. Direct Bill (If paying by Direct Bill the first premium is required at time of submission)
   - ➔ Select frequency: ☐ Quarterly ☐ Semi-Annual ☐ Annual
   - ➔ If billing address is different than home address, please enter here:

Billing Address:

Street:_____

City: _____ State: _____ Zip code: _____

Billing Authorization

Please read the following carefully.

The accountholder of the method of payment provided during this enrollment process authorizes and requests the Insurer, or its designee, to initiate automatic payments against such indicated payment method for the payment of premiums and other indicated monthly dues included in the plan(s) being purchased during this enrollment process. Accountholder agrees that the electronic payment authorization for such automatic payments may be terminated by providing written notice to the Insurer. If the payment dates fall on a weekend or holiday, I understand that the payments may be executed on the previous business day. I understand that if I choose a draft date of the 29th, 30th or 31st of the month we may choose to change your payment to be executed on the 28th of each month. For Automated Clearing House (ACH) debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that the Insurer may at its discretion attempt to process the charge again. I certify that I am an authorized user of this method of payment and will not dispute the scheduled transactions; provided the transactions correspond to the terms indicated in this authorization form.

Signature of Primary Insured Date

Confidential Communication Requests

You may request that communication containing medical information be communicated to You at a specific mail or email address or specific telephone number, as designated by You. You may request confidential communication in the form and format requested by You, if it is readily producible in the requested form and format, or at alternative locations. Your Confidential Communication Request must be in writing or by electronic transmission. Please visit https://allstatehealth.com or call Our Customer Service Department at 888-781-0585 if You are interested in making a Confidential Communication Request.

Medicare Supplement Activity Tracker Discount Authorization Form

Please fill out the following fields:

Applicant name: _____

Applicant phone number: _____

Applicant email address: _____
(An email address is required to participate in the Activity Tracker Discount program. By supplying your email address, you are agreeing to receive email correspondence about the Activity Tracker Discount program.)

Selling agent name: _____

Selling agent phone number: _____

☐ Yes, I acknowledge I own an activity tracker or wearable device, and I am willing to share my fitness data.

☐ No, I do not want to participate and share my fitness data.

Authorize and Agree:

☐ By selecting this box, I acknowledge that I own an activity tracker or wearable device. I agree to register my activity tracker device within 30 days and share my activity data with Allstate Health Solutions insurance. I understand that if I do not register my device, my Activity Tracker Discount will be removed and my Medicare Supplement Insurance premium will be adjusted.

☐ By selecting this box, I agree to receive email correspondence from Allstate Health Solutions about the Activity Tracker program at the email address supplied above.

Applicant signature: _____

Date: _____

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 1070, Winston-Salem, NC 27102-1070, 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)

N-HHA-MS-M

NATIONAL HEALTH INSURANCE COMPANY

Definition of Eligible Person for Guaranteed Issue

The following are definitions of the categories of individuals who are eligible for Guaranteed Issue:

- ☐ 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 ; 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; 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

- ☐ 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; or

- ☐ Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, substantial violation of a material policy provision, or material misrepresentation; 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; 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; 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; or

- ☐ Other Guarantee Issue rights available under State law.

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

Outline of Medicare Supplement Plans A, F, High Deductible F, G, N

This chart shows the benefit included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants' first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F. Note: A ✓ means 100% of the benefit is paid.

	Plans Available to All Applicants								Medicare first eligible before 2020 only	
Benefits	**A**	**B**	**D**	**G[1]**	**K**	**L**	**M**	**N**	**C**	**F[1]**
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2023[2]					6940[2]	3470[2]				

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of $2700 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

NATIONAL HEALTH INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan A
Attained Age Premium Rates
Rates Effective Upon Approval

Attained Age	Unisex	
	Preferred	Standard
0-64	349.54	401.88
65	139.82	160.75
66	139.82	160.75
67	139.82	160.75
68	139.82	160.75
69	145.37	167.16
70	151.14	173.89
71	157.23	180.83
72	163.32	187.88
73	169.51	195.04
74	175.81	202.30
75	182.12	209.57
76	188.52	216.94
77	194.93	224.31
78	201.34	231.68
79	207.75	239.05
80	214.16	246.42
81	220.57	253.79
82	227.19	261.37
83	233.81	269.06
84	240.33	276.54
85	246.95	284.12
86	253.36	291.49
87	259.77	298.86
88	266.28	306.34
89	272.91	314.03
90	279.74	321.93
91	286.79	330.05
92	293.95	338.38
93	301.21	346.82
94	308.69	355.47
95	316.38	364.34
96	324.28	373.42
97	332.40	382.71
98	340.73	392.22
99+	349.17	401.94

Rate Calculator

Monthly Rate

A - Monthly Rate (use table above)
B - Area Factor (see area factors below)
C - Input Household Discount (1.0 if not applicable, 0.93 if roommate HHD applies, 0.9 if dual HHD applies)
D - Input Activity Tracker Discount (1.0 if not applicable, 0.95 if discount applies)
E - Input Annual Pay Discount (1.0 if not applicable, 0.9 if discount applies)
F - Calculate Monthly Rate (rounded to the nearest penny) F=A*B*C*D*E

Quarterly, Semi-Annual, or Annual Rate

G - Input Modal Factor (Quarterly - multiply by 3, Semi-Annual - multiply by 6, Annual - multiply by 12)
H - Calculate Final Modal Billing Rate (rounded to the nearest penny) H=F*G

Roommate Household Discount: 7%

Dual Household Discount (applies if multiple people in the same Household have or are applying for National General Medicare Supplement policies): 10%

Annual Pay Discount: 10%

Activity Tracker "Wearable" Discount: 5%

The rates above do not include a one time $25 policy fee.

Area Factors:

California Zip Codes	Factor
Area 1: 900-918, 926-930	1.500
Area 2: 919-925, 931, 941-949	1.250
Area 3: All Other Zip Codes	1.150

NATIONAL HEALTH INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan F
Attained Age Premium Rates
Rates Effective Upon Approval

Attained Age	Unisex	
	Preferred	Standard
0-64	457.12	525.63
65	182.85	210.25
66	182.85	210.25
67	182.85	210.25
68	182.85	210.25
69	190.15	218.61
70	197.77	227.40
71	205.70	236.50
72	213.75	245.70
73	221.89	255.01
74	230.15	264.43
75	238.40	273.95
76	246.76	283.58
77	255.12	293.21
78	263.59	302.84
79	272.05	312.58
80	280.52	322.31
81	288.98	331.94
82	297.66	341.89
83	306.44	351.94
84	314.90	361.67
85	323.48	371.51
86	331.83	381.14
87	340.19	390.77
88	348.66	400.51
89	357.34	410.56
90	366.33	420.82
91	375.54	431.41
92	384.95	442.20
93	394.48	453.20
94	404.32	464.42
95	414.37	475.95
96	424.74	487.91
97	435.32	500.08
98	446.22	512.57
99+	457.33	525.26

Rate Calculator

Monthly Rate

A - Monthly Rate (use table above)		
B - Area Factor (see area factors below)		
C - Input Household Discount (1.0 if not applicable, 0.93 if roommate HHD applies, 0.9 if dual HHD applies)		
D - Input Activity Tracker Discount (1.0 if not applicable, 0.95 if discount applies)		
E - Input Annual Pay Discount (1.0 if not applicable, 0.9 if discount applies)		
F - Calculate Monthly Rate (rounded to the nearest penny)		F=A*B*C*D*E

Quarterly, Semi-Annual, or Annual Rate

G - Input Modal Factor (Quarterly - multiply by 3, Semi-Annual - multiply by 6, Annual - multiply by 12)		
H - Calculate Final Modal Billing Rate (rounded to the nearest penny)		H=F*G

Roommate Household Discount:	7%
Dual Household Discount (applies if multiple people in the same Household have or are applying for National General Medicare Supplement policies):	10%
Annual Pay Discount:	10%
Activity Tracker "Wearable" Discount:	5%

The rates above do not include a one time $25 policy fee.

Area Factors:

California Zip Codes	Factor
Area 1: 900-918, 926-930	1.500
Area 2: 919-925, 931, 941-949	1.250
Area 3: All Other Zip Codes	1.150

NATIONAL HEALTH INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan High F
Attained Age Premium Rates
Rates Effective Upon Approval

Attained Age	Unisex	
	Preferred	Standard
0-64	134.02	153.73
65	53.61	61.49
66	53.61	61.49
67	53.61	61.49
68	53.61	61.49
69	55.70	63.99
70	57.90	66.58
71	60.20	69.28
72	62.59	71.97
73	64.99	74.67
74	67.38	77.46
75	69.78	80.26
76	72.17	83.06
77	74.67	85.85
78	77.17	88.64
79	79.66	91.44
80	82.16	94.24
81	84.65	97.03
82	87.15	99.93
83	89.74	102.82
84	92.24	105.72
85	94.73	108.61
86	97.23	111.40
87	99.73	114.20
88	102.22	117.10
89	104.82	119.99
90	107.41	122.99
91	110.11	126.08
92	112.90	129.27
93	115.70	132.47
94	118.59	135.76
95	121.49	139.16
96	124.48	142.65
97	127.58	146.24
98	130.77	149.94
99+	134.07	153.63

Rate Calculator

Monthly Rate

A - Monthly Rate (use table above)		
B - Area Factor (see area factors below)		
C - Input Household Discount (1.0 if not applicable, 0.93 if roommate HHD applies, 0.9 if dual HHD applies)		
D - Input Activity Tracker Discount (1.0 if not applicable, 0.95 if discount applies)		
E - Input Annual Pay Discount (1.0 if not applicable, 0.9 if discount applies)		
F - Calculate Monthly Rate (rounded to the nearest penny)		F=A*B*C*D*E

Quarterly, Semi-Annual, or Annual Rate

G - Input Modal Factor (Quarterly - multiply by 3, Semi-Annual - multiply by 6, Annual - multiply by 12)		
H - Calculate Final Modal Billing Rate (rounded to the nearest penny)		H=F*G

Roommate Household Discount:	7%
Dual Household Discount (applies if multiple people in the same Household have or are applying for National General Medicare Supplement policies):	10%
Annual Pay Discount:	10%
Activity Tracker "Wearable" Discount:	5%

The rates above do not include a one time $25 policy fee.

Area Factors:

California Zip Codes	Factor
Area 1: 900-918, 926-930	1.500
Area 2: 919-925, 931, 941-949	1.250
Area 3: All Other Zip Codes	1.150

NATIONAL HEALTH INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan G
Attained Age Premium Rates
Rates Effective Upon Approval

Attained Age	Unisex	
	Preferred	Standard
0-64	389.87	448.08
65	155.95	179.23
66	155.95	179.23
67	155.95	179.23
68	155.95	179.23
69	162.14	186.39
70	168.66	193.87
71	175.39	201.66
72	182.22	209.57
73	189.17	217.58
74	196.21	225.59
75	203.27	233.71
76	210.42	241.93
77	217.58	250.16
78	224.74	258.38
79	231.89	266.60
80	239.05	274.83
81	246.20	283.06
82	253.57	291.60
83	261.05	300.14
84	268.31	308.48
85	275.68	316.91
86	282.84	325.14
87	290.00	333.36
88	297.26	341.69
89	304.74	350.24
90	312.43	359.00
91	320.23	367.97
92	328.24	377.26
93	336.35	386.66
94	344.69	396.28
95	353.23	406.10
96	362.10	416.25
97	371.18	426.61
98	380.47	437.29
99+	389.97	448.19

Rate Calculator

Monthly Rate

A - Monthly Rate (use table above)		
B - Area Factor (see area factors below)		
C - Input Household Discount (1.0 if not applicable, 0.93 if roommate HHD applies, 0.9 if dual HHD applies)		
D - Input Activity Tracker Discount (1.0 if not applicable, 0.95 if discount applies)		
E - Input Annual Pay Discount (1.0 if not applicable, 0.9 if discount applies)		
F - Calculate Monthly Rate (rounded to the nearest penny)		F=A*B*C*D*E

Quarterly, Semi-Annual, or Annual Rate

G - Input Modal Factor (Quarterly - multiply by 3, Semi-Annual - multiply by 6, Annual - multiply by 12)		
H - Calculate Final Modal Billing Rate (rounded to the nearest penny)		H=F*G

Roommate Household Discount:	7%
Dual Household Discount (applies if multiple people in the same Household have or are applying for National General Medicare Supplement policies):	10%
Annual Pay Discount:	10%
Activity Tracker "Wearable" Discount:	5%

The rates above do not include a one time $25 policy fee.

Area Factors:

California Zip Codes	Factor
Area 1: 900-918, 926-930	1.500
Area 2: 919-925, 931, 941-949	1.250
Area 3: All Other Zip Codes	1.150

NATIONAL HEALTH INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan N
Attained Age Premium Rates
Rates Effective Upon Approval

Attained Age	Unisex	
	Preferred	Standard
0-64	308.08	353.76
65	123.23	141.50
66	123.23	141.50
67	123.23	141.50
68	123.23	141.50
69	128.11	147.21
70	133.20	153.13
71	138.49	159.26
72	143.89	165.49
73	149.39	171.82
74	154.90	178.15
75	160.50	184.59
76	166.11	191.03
77	171.72	197.57
78	177.43	204.11
79	183.13	210.65
80	188.84	217.19
81	194.56	223.73
82	200.37	230.48
83	206.29	237.22
84	212.00	243.77
85	217.81	250.41
86	223.42	256.85
87	229.02	263.28
88	234.73	269.82
89	240.65	276.57
90	246.67	283.53
91	252.90	290.69
92	259.23	297.96
93	265.67	305.33
94	272.21	312.91
95	278.96	320.69
96	285.92	328.69
97	293.08	336.89
98	300.35	345.30
99+	307.82	353.92

Rate Calculator

Monthly Rate

A - Monthly Rate (use table above)		
B - Area Factor (see area factors below)		
C - Input Household Discount (1.0 if not applicable, 0.93 if roommate HHD applies, 0.9 if dual HHD applies)		
D - Input Activity Tracker Discount (1.0 if not applicable, 0.95 if discount applies)		
E - Input Annual Pay Discount (1.0 if not applicable, 0.9 if discount applies)		
F - Calculate Monthly Rate (rounded to the nearest penny)		F=A*B*C*D*E

Quarterly, Semi-Annual, or Annual Rate

G - Input Modal Factor (Quarterly - multiply by 3, Semi-Annual - multiply by 6, Annual - multiply by 12)		
H - Calculate Final Modal Billing Rate (rounded to the nearest penny)		H=F*G

Roommate Household Discount:	7%
Dual Household Discount (applies if multiple people in the same Household have or are applying for National General Medicare Supplement policies):	10%
Annual Pay Discount:	10%
Activity Tracker "Wearable" Discount:	5%

The rates above do not include a one time $25 policy fee.

Area Factors:

California Zip Codes	Factor
Area 1: 900-918, 926-930	1.500
Area 2: 919-925, 931, 941-949	1.250
Area 3: All Other Zip Codes	1.150

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 1070, Winston-Salem, NC 27102-1070. 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 $1600	$0	$1600 (Part A deductible)
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after -While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	$0	Up to $200 a day All
101st day and after	$0	$0	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 $226 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 $226 of Medicare Approved Amounts **	$0	$0	$226 (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 $226 of Medicare Approved Amounts**	$0	$0	$226 (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 $226 of Medicare Approved Amounts**	$0	$0	$226 (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 $1600	$1600 (Part A deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after -While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	Up to $200 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 $226 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 $226 of Medicare Approved Amounts **	$0	$226 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $226 of Medicare Approved Amounts**	$0	$226 (Part B Deductible)	$0
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 $226 of Medicare Approved Amounts**	$0	$226 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$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	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	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.*

*** This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2700 deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are $2700. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1600	$1600 (Part A deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after -While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	Up to $200 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 $226 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.*

*** This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2700 deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are $2700. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-IN OR OUT OFTHE 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 $226 of Medicare Approved Amounts ** Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $0 Generally 20%	 $226 (Unless Part B Deductible has been met) $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $226 of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 $226 (Unless Part B Deductible has been met) $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 $226 of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $226 (Unless Part B Deductible has been met) $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 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 $1600	$1600 (Part A deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after -While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	Up to $200 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 $226 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 $226 of Medicare Approved Amounts **	$0	$0	$226 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	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	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	$0	All costs	$0
Next $226 of Medicare Approved Amounts**	$0	$0	$226 (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 $226 of Medicare Approved Amounts**	$0	$0	$226 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$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	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime Maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Allstate Health Solutions
ATTN: Privacy Office
1515 N. Rivercenter Dr., Ste 135
Milwaukee, WI 53212
allstatehealth.com

your right to know what we do with your information

It's your right to know how your medical information may be used or disclosed — and it's our responsibility to tell you. This document explains how information we gather is used.

Your rights

At any time, you can —

- get a copy of your health and claims records.
- correct your health and claims records.
- request confidential communication.
- ask us to limit the information we share.
- get a list of those with whom we've shared your information.
- get a copy of this privacy notice.
- choose someone to act for you.
- file a complaint if you believe your privacy rights have been violated.

See page 2 for more information on these rights and how to apply them.

You decide

You choose how we —

- answer coverage questions from your family and friends.
- provide disaster relief.
- market our services and sell your information.

See page 3 for more information on these choices and how to apply them.

Our responsibility

Your information may be used when we —

- help manage the health care treatment you receive.
- run our organization.
- pay for your health services.
- administer your health plan.
- help with public health and safety issues.
- do research.
- comply with the law.
- respond to organ and tissue donation requests and work with a medical examiner or funeral director.
- address workers' compensation, law enforcement, and other government requests.
- respond to lawsuits and legal actions.

See pages 3 and 4 to read more about these uses and disclosures.

Your rights, in a little more detail.

Your health and claims records	• Ask us how to get a copy of your health and claims records — or any other health information we have about you. • We will provide a copy, or a summary, of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Correct health and claims records	• Ask us how to correct your health and claims records if you believe they are incorrect or incomplete. • We may say “no” to your request, but we’ll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say “no” if it would affect your care.
Get a list of those with whom we’ve shared information	• You can ask for a list of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this 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. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney, or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• If you feel we have violated your rights, contact us using the information on page 1. • 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/. • We will not retaliate against you for filing a complaint.

You choose what we share.

Let us know how we can share your information in these types of circumstances	• If something happens and your family, close friends or others involved in payment for your care need information to help you. • Share information in a disaster relief situation. • If you are not able to tell us your preference, we may 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.
We never share your information unless you give us written permission	• For marketing purposes. • Sell your information.

Typical reasons your information gets shared.

To help manage your health care and treatments	• 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 are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
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.
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 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 when an individual dies.
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.

We can share health information about you to alert state or local authorities, if we believe someone is a victim of child abuse or neglect, or domestic violence.

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.

Most uses and disclosures of substance use treatment, behavioral health records, or psychotherapy notes require us to obtain an authorization. If your health information 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.

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the Notice of Privacy Practices electronically.

You may review and print a copy of our most current Notice of Privacy Practices at our website, www.allstatehealth.com, or you may request a paper copy by calling our customer service department at (888) 781-0585.

Other items we are responsible for	• We are required by law to maintain the privacy and security of your protected health information. • We will let you know promptly if a breach occurs that may have compromised the privacy or security of your 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

We can change the terms of this notice, and the changes will apply to all information we have about you.

The Effective Date of this Notice of Privacy Practices is October 1, 2022.

This Notice of Privacy Practices applies to:

National Health Insurance Company, Integon National Insurance Company and Integon Indemnity Corporation.