GROUP MEDICARE SUPPLEMENT INSURANCE CERTIFICATE

PLAN G

IMPORTANT NOTICE

Please read the copy of the application attached to this policy. Carefully check the application and write to Our Home Office within ten (10) days if any information shown on it is not correct and complete, or if any past medical history has been left out of the application. This application is a part of the policy and the policy was issued on the basis that answers to all questions and the information shown on the application are correct and complete.

THIRTY (30) DAY RIGHT TO RETURN CERTIFICATE

We want You to be satisfied with the terms of this Certificate. If You are not satisfied with this Certificate for any reason, You can return this Certificate to Us within thirty (30) days after You receive it by mailing it to Our Home Office. The return of this Certificate will void this Certificate from the Certificate Effective Date. We will refund any Premium You paid for this Certificate, less the amount of any claims paid.

www.fbhealthplans.com

CON-TNG-CERTG-FL24-002
Effective January 1, 2024

FARM BUREAU HEALTH PLANS

Home Office: P.O. Box 1801, Columbia, TN 38402-1801, 1-877-874-8323

GROUP MEDICARE SUPPLEMENT INSURANCE CERTIFICATE PLAN G

This Certificate is issued in consideration of the Enrollment Application for Coverage under the group policy issued to the Tennessee Rural Health Improvement Association (the Policyholder or Tennessee Farm Bureau) and payment of the initial Premium. A copy of Your Enrollment Application is attached to this Certificate. Your Coverage is effective on the Certificate Effective Date shown on the Schedule Declarations Page.

This Certificate is a legal document between You and Us. It describes the terms and conditions of Your Coverage. We want You to understand the terms of this Certificate. **PLEASE READ YOUR CERTIFICATE CAREFULLY.**

GUARANTEED RENEWABLE

This Certificate is guaranteed renewable for life. This means that We cannot cancel this Certificate for any reason other than cancellation of Your Tennessee Farm Bureau membership, nonpayment of Premium or material misrepresentation.

PREMIUM CHANGES

The Premium for this Certificate is shown on the Schedule Declarations Page. You will have an attained age-rated adjustment each year with the first billing following Your birthday.

Subject to rate requirements applicable in the State of Tennessee, We may change the Premium for this Certificate at any time. Any Premium change will be made only when We change the Premium for all certificates in the same Premium Class on the same form as this Certificate that are issued in the State of Tennessee. We will give You at least thirty (30) days prior written notice before the effective date of any Premium change. We will not change the Premium for this Certificate until such Premium change has been filed with and approved by the Tennessee Department of Commerce and Insurance, as applicable. Premiums will never be changed due to a change in Your health, the number of claims You file, or Your type of work.

CHANGES IN MEDICARE

Benefits provided under this Certificate are designed to cover cost sharing amounts under Medicare and will be changed automatically to coincide with any changes in the applicable Medicare Deductible, Copayment, or Coinsurance amounts. Premium also may be changed to correspond to benefit changes. Please refer to Section 5, *Automatic Adjustment for Changes In Medicare Benefits,* for more details. **This Certificate does not duplicate benefits provided by Medicare.**

WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud as determined by a court of law.

NOTICE TO BUYER: **This Certificate may not cover all of Your medical expenses.**

Chief Executive Officer **Secretary**

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SECTION 1 – DEFINITIONS

This section provides an alphabetical list of certain terms and their meanings as used in this Certificate. Defined terms are capitalized wherever they occur in this Certificate.

Admission means entry into a facility as a registered Inpatient according to the rules and regulations of that facility. An Admission ends when You are discharged or released from the facility.

Accident means Injury or injuries sustained by the Insured which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance Coverage is in force under this group policy. It does not mean Injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

Benefit Period has the same meaning as it does in Medicare. A Benefit Period begins the day You go into a Hospital or Skilled Nursing Facility (SNF). The Benefit Period ends when You have not received any Inpatient Hospital care (or skilled care in an SNF) for sixty (60) consecutive days. If You go into a Hospital or Skilled Nursing Facility after a Benefit Period has ended, a new Benefit Period begins. The Inpatient Hospital Deductible required by Medicare applies to each Benefit Period. There is no limit to the number of Benefit Periods.

Benefit Plan means the Medicare Supplement Insurance plan provided under this Certificate as shown on the Schedule Declarations Page of this Certificate and as referenced in this Certificate.

Calendar Year means the twelve (12) month period that begins on January 1 and ends with December 31. When You first become covered under the group policy, Your first Calendar Year begins on Your Certificate Effective Date and ends on the following December 31. Thereafter, Your Calendar Year begins on January 1 and ends on December 31 of each year.

Certificate means the document issued to You which indicates the Coverage and benefits provided under the group policy, as elected by You. We will issue a Certificate to You upon Your enrollment under the group policy.

Certificate Effective Date means Your effective date of Coverage under the group policy. The Certificate Effective Date is shown on the Schedule Declarations Page of Your Certificate.

Certificateholder means the person who may exercise the rights set forth in this Certificate. The Certificateholder is the person who applied for Coverage under the group policy and to whom this Certificate is issued. The Certificateholder is named on the Schedule Declarations Page of this Certificate. The Certificateholder is also the Insured.

Class or **Classification** means, as used in reference to Your Premium, the plan of Coverage and Your attained age.

Clean Claim means a claim submitted by a Provider for payment under the group policy issued in Tennessee that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

Coinsurance means Your share of the cost for medical services or supplies. Coinsurance is usually a percentage. Coinsurance amounts are set by Medicare each year.

Confinement means the number of days spent as an Inpatient following each Admission to a facility. If seven (7) or more days have not lapsed between the date of discharge from a facility and the date of the next Admission, the days will be counted as one (1) Confinement. This occurs whether or not We provide benefits during the Confinement. One (1) Confinement may consist of several Admissions.

Continuous Period of Creditable Coverage means the period during which You were covered by Creditable Coverage if, during the period of coverage, You had no breaks in coverage greater than sixty-three (63) days.

Copayment means Your share of the cost for certain medical services or supplies You receive. A Copayment is usually a fixed dollar amount rather than a percentage. Copayment amounts are set by Medicare each year.

Coverage means the benefits provided for You under the group policy for the Medicare Supplement Insurance plan shown on the Schedule Declarations Page.

Creditable Coverage means coverage provided under any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928;
5. Chapter 55 of Title 10 United States Code (CHAMPUS);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool;
8. A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);
9. A public health plan as defined in federal regulations; or
10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

Deductible means the amount You must pay for health care services before Medicare or Your other insurance begins to pay. For Medicare Part A, the Deductible is the fixed amount Medicare does not pay during the first sixty (60) days of Hospital Confinement during a Benefit Period. For Medicare Part B, the Deductible is the amount You must pay each Calendar Year before benefits can be paid under Medicare Part B. Deductible amounts are set by Medicare each year.

Enrollment Application means the form used by a member to enroll for Coverage under the group policy. The Enrollment Application will be attached to Your Certificate when Your Certificate is issued.

Guaranteed Issue Coverage means that on the date of application, You were eligible to have the Medicare Supplement Insurance provided under the group policy issued to You on a guaranteed issue basis with no Pre-Existing Condition limitations. Qualifications for Guaranteed Issue Coverage under the group policy consist of You applying for Coverage under the group policy within sixty-three (63) days of losing Your other health coverage as listed below:

1. You were in a Medicare Advantage plan (also known as Medicare Part C), and the plan was leaving the Medicare program, discontinues plans in Your area, or You moved out of the Medicare Advantage plan's service area;
2. You were in the original Medicare plan (Medicare Part A and Part B) and had coverage through an employer group health plan (including retiree or COBRA) or union plan that pays after Medicare pays and the employer group health plan or union plan terminated;
3. You joined a Medicare Advantage plan when You first became eligible for Medicare Part A at age sixty-five (65) and within twelve (12) months of joining, You decided You wanted to switch to original Medicare;
4. You dropped Your Medicare Supplement Insurance plan to join a Medicare Advantage plan for the very first time, have been in the Medicare Advantage plan less that twelve (12) months, and wanted to switch back to original Medicare; or
5. You are age sixty-five (65) or older with Medicare and are disenrolled from Medicaid.

Hospital means an institution that is run for the care and treatment of Sick or Injured persons as Inpatients and which, on its premises or in facilities available to the Hospital on a pre-arranged basis, meets fully each of the following requirements:

1. Is operated in accordance with the laws pertaining to Hospitals in the jurisdiction in which it is located;
2. Is under the supervision of a medical staff and has one (1) or more Physicians available at all times;
3. Provides twenty-four (24) hours a day service by Graduate Registered Nurses (RNs); and
4. Is not, primarily:
    a. A place for the aged;
    b. A nursing or convalescent home;
    c. A facility providing custodial, educational or rehabilitative care; or
    d. A facility for the treatment of drug abuse and alcoholism.

You will not be considered Hospital confined if You are in a special unit of a Hospital used as a nursing, rest, or convalescent home.

Injury or **Injured** means a non-occupational bodily harm which is the direct result of an Accident.

Inpatient means a registered bed patient in a facility for which a room and board charge is made.

Inpatient Hospital Services means Inpatient Hospital Services as defined by Medicare.

Insured means the person to whom insurance Coverage is provided under the group policy and is named as the Insured on the Schedule Declarations Page of this Certificate issued to the Insured. The Insured is also the Certificateholder. The Insured is also referred to as “You” or “Your”.

Lifetime Reserve Days means the sixty (60) additional days of Hospital Confinement benefits provided by Medicare Part A which You may use after the first ninety (90) days of Hospital Confinement benefits during a Medicare Benefit Period. Lifetime Reserve Days may be used only once during Your lifetime. For each Lifetime Reserve Day, Medicare pays all covered costs except for a daily Coinsurance.

Medicaid means any state medical assistance program under Title XIX of the Social Security Act, as it is now and as it may be amended.

Medical Condition means any disease, disorder, Sickness, Injury, or bodily dysfunction including a mental or nervous disorder.

Medicare means the “Health Insurance for the Aged Act,” Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare-Approved Amount means the total amount approved by Medicare that a Physician or other Provider who accepts assignment may be paid. This amount may be less than the actual amount a Physician or other Provider charges.

Medicare-Eligible Expense means an expense covered by Medicare Parts A and B to the extent recognized as reasonable and medically necessary by Medicare.

Medicare Open Enrollment means a one-time-only six (6) month period when You can buy any Medigap policy You want that is sold in Your state. It starts in the first month that You are both covered under Medicare Part B and You are at least age sixty-five (65) or older, or You become enrolled for benefits under Medicare Part B without regard to age, or You qualify for Guaranteed Issue Coverage as defined in this section. During this period, You cannot be denied coverage or charged more due to past or present health problems.

Medicare Part A means insurance to cover Hospital expenses, such as room and board and other Inpatient Hospital Services.

Medicare Part B means insurance to cover medical expenses, such as Physicians' services, Outpatient Hospital Services and a number of other non-Hospital medical services and supplies.

Medicare Supplement Insurance means Accident and Sickness insurance which is designed primarily as a supplement to reimbursements under Medicare for Medicare-Eligible Expenses.

Nurse means one (1) of the following licensed professionals: (1) Registered Nurse or Graduate Registered Nurse (R.N.); (2) Licensed Practical Nurse (L.P.N.); or (3) Licensed Vocational Nurse (L.V.N.).

Outpatient means someone who receives medical services or supplies while not Hospital confined.

Outpatient Hospital Services means Outpatient Hospital Services as defined by Medicare.

Physician means a licensed practitioner of the healing arts practicing within the scope of his or her license in treating an Injury or Sickness.

Physician Services means Physician Services as defined by Medicare.

Policyholder means the holder of the group policy. The Policyholder is named on the Schedule Declarations Page of this Certificate.

Pre-Existing Condition means a condition for which medical advice was given or treatment was recommended by or received from a Physician within six (6) months prior to Your Certificate Effective Date.

Pre-Existing Condition Waiting Period means the six (6) month period beginning with Your Certificate Effective Date. This is the period during which no benefits are payable for care, treatment or services for Pre-Existing Conditions.

Premium means the amount You must pay for Your Coverage under the group policy. The initial Premium amount for Your Coverage is shown on the Schedule Declarations Page of this Certificate. Also, refer to Section 4, *Premiums*, for more information.

Provider means an individual or entity duly licensed or legally authorized to provide health care services.

Sick or Sickness means a non-occupational illness or disease which first manifests itself after Your Certificate Effective Date while You are covered under the group policy. Sickness does not include Sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

Skilled Nursing Facility Services means Skilled Nursing Facility Services as defined by Medicare.

You or **Your** means the Insured. It also means the Certificateholder.

We, Us, Our, or Company means Farm Bureau Health Plans .

SECTION 2 – PLAN G BENEFITS

The benefits provided under the group policy are designed to coordinate with the benefits provided by the original Medicare program. Unless specifically stated otherwise, the group policy does not cover any service or portion of a service that is not a Medicare-Eligible Expense. This Certificate provides Medicare Supplement Insurance Plan G benefits. When You receive services for Medicare-Eligible Expenses, We will pay the benefits provided in this Section. We will not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents. You may only elect and be enrolled under one (1) Medicare Supplement Insurance plan.

INPATIENT HOSPITAL CONFINEMENT BENEFITS (MEDICARE PART A)

Coinsurance Benefit
After You have been hospitalized for sixty (60) days, You must share the cost of the Hospital care expenses with Medicare. This is called Coinsurance. We will pay one hundred percent (100%) of the Part A Medicare-Eligible Expenses for each day of Inpatient Hospital Confinement You incur from the sixty-first (61st) day through the ninetieth (90th) day in each Medicare Benefit Period to the extent such expenses are not covered by Medicare.

Lifetime Reserve Days Benefit
We will pay one hundred percent (100%) of the Part A Medicare-Eligible Expenses of each Lifetime Reserve Day of Inpatient Hospital Confinement You incur to the extent not covered by Medicare. Our payments will start on the ninety-first (91st) day of Your Inpatient Hospital Confinement and before Your Lifetime Reserve Days expire. Lifetime Reserve Days are nonrenewable and limited to sixty (60) days during Your lifetime.

Medicare Exhaustion Benefit
After all of Your Medicare Inpatient Hospital Confinement benefits are exhausted, including Your Lifetime Reserve Days, We will pay one hundred percent (100%) of the Part A Medicare-Eligible Expenses You incur for Inpatient Hospital Confinement. Benefits are payable at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment. Medicare exhaustion benefits are limited to a maximum of three hundred sixty-five (365) days of Inpatient Hospital Confinement payable during Your lifetime.

Please Note: For Inpatient Hospital Confinement payments, the group policy will consider payment up to the Hospital's most common semi-private room rate. If You stay in a private room, You will be responsible for the difference between the private room rate and the semi-private room rate.

BLOOD BENEFIT (MEDICARE PARTS A AND B)
Each Calendar Year, We will pay the reasonable costs under Medicare Parts A and B for:

1. The first three (3) pints of blood; or
2. Equivalent quantities of packed red blood cells, as defined under federal regulations; unless replaced in accordance with federal regulations.

MEDICARE PART B COINSURANCE BENEFIT
Medicare Part B pays a percentage of the Medicare-Approved Amount for Medicare-Eligible Expenses after the Part B Deductible. The remaining percentage is Your Part B Coinsurance. After the Medicare Part B Calendar Year Deductible has been satisfied, We will pay Your Medicare Part B Coinsurance amount not paid by Medicare for Medicare-Eligible Expenses or the fixed Copayment for certain Outpatient Hospital Services. The covered amounts include amounts charged by the Outpatient department of a Hospital as well as professional charges for Physician Services. We will also cover one hundred percent (100%) of Your Part B Coinsurance for Medicare-Eligible Expenses for preventive care.

HOSPICE CARE
We will pay the cost sharing of all Part A Medicare-Eligible Expenses for hospice care and respite care. Such cost sharing may be a Copayment or Coinsurance, as applicable.

ADDITIONAL PLAN G BENEFITS

We will pay the following additional benefits when You receive services for Medicare-Eligible Expenses. These additional benefits are subject to the same terms and conditions as the Basic Core Benefits.

Inpatient Hospital Confinement Deductible Benefit (Medicare Part A)
When the Insured is confined in a Hospital as an Inpatient, We will pay one hundred percent (100%) of the Medicare Part A Inpatient Hospital Deductible amount due for each Benefit Period.

Skilled Nursing Facility Confinement Benefit (Medicare Part A)
When the Insured is confined in a Skilled Nursing Facility for post-Hospital care eligible under Medicare Part A, We will pay the actual billed charges, up to the daily Coinsurance amount, for each day of Confinement from the twenty-first (21st) day through the one hundredth (100th) day, during each Medicare Benefit Period.

Medicare Part B Excess Charges
We will pay one hundred percent (100%) of the Medicare Part B excess charges. These excess charges consist of Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.

However, when a Provider of medical services accepts an assignment of benefits, no excess charges will be payable by Us. When a Provider of medical services does not accept an assignment of benefits, the amount of excess charge that We will consider cannot exceed any charge limitation established by the Medicare program or state law.

Emergency Care in a Foreign Country Benefit
If the Insured receives emergency care while in a foreign country, We will pay eighty percent (80%) of the billed Medicare-Eligible Expenses incurred for Hospital, Physician and medical services to the extent such expenses are not covered by Medicare, after a two hundred fifty dollars ($250) Calendar Year Deductible has been satisfied by the Insured. Benefits are payable only for emergency care that would have been covered by Medicare to the extent such emergency care would have been covered by Medicare if provided in the United States. Benefits are limited to:

1. Emergency care which begins during the first sixty (60) consecutive days of each trip the Insured makes outside of the United States; and
2. A maximum benefit payable of fifty thousand dollars ($50,000) during the Insured's lifetime.

SECTION 3 – WHEN COVERAGE TAKES EFFECT AND TERMINATES

Persons Eligible for Coverage
To be eligible for Coverage under the group policy, a person must:
1. Be enrolled as an active member in the Tennessee Farm Bureau;
2. Be eligible for Medicare; and
3. Be enrolled in both Medicare Parts A and B; and
4. Apply for Coverage under the group policy and pay the required Premium.

Effective Date of Coverage
Your effective date of Coverage is the Certificate Effective Date shown on the Schedule Declarations Page of this Certificate.

Policy Termination
If the Policyholder terminates the group policy, We will send You a written notice of such termination at least forty-five (45) days in advance of the effective date of termination. (See the **Conversion Privilege** provision below regarding Your rights to convert Your Coverage under the group policy to an individual conversion policy).

Termination of Coverage for Insureds
Your Coverage under the group policy will terminate on the earliest of the following:

1. Upon Our receipt of Your written notice to terminate Your Coverage under the group policy, We will terminate Your Coverage on the following paid-to date. Your termination notice must be received at Our Home Office at least ten (10) days in advance of the requested termination date;
2. The paid-to date preceding the date You fail to pay the required Premium for Your Coverage under the group policy, subject to the grace period;
3. The paid-to date following the date upon which notice is provided by the Policyholder that Your membership in the Tennessee Farm Bureau has been cancelled;
4. If We discover a material misrepresentation on Your Enrollment Application, subject to the **Incontestability** provision in Section 9, *General Provisions,* of this Certificate. Your Coverage under the group policy will be terminated from Your Certificate Effective Date; or
5. The date of Your death.

Termination of Your Coverage under the group policy will be without prejudice to any continuous loss that began while this Certificate was in force.

SUSPENSION AND REINSTITUTION OF COVERAGE

Suspension Due to Entitlement to Medical Assistance under Title XIX of the Social Security Act (Medicaid)
Benefits and Premium under the group policy will be suspended at Your request for a period, not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act (Medicaid). You must notify Us within ninety (90) days after You become entitled to such assistance.

If suspension occurs and if You lose entitlement to the medical assistance, Your Coverage under this group policy will be automatically reinstituted, effective as of the date of the termination of the entitlement if You:

1. Provide notice of loss of the entitlement within ninety (90) days after the date of the loss; and
2. Pay the Premium attributable to the period.

Upon receipt of timely notice, We will return that portion of the Premium attributable to the period of time Your Coverage is suspended. Your refunded Premium will be reduced by the amount of any claims paid for the period You are eligible.

Suspension Due to Federal Regulation
At your request, the benefits and Premium applicable to Your Coverage under the group policy will be suspended for any period that may be provided by federal regulation, if You are:

1. Entitled to benefits under Section 226(b) of the Social Security Act; and
2. Covered under a group health plan as defined in Section 1862(b)(1)(A)(v) of the Social Security Act.

If you lose the coverage described above, Coverage under the group policy, suspended due to federal regulation, may be automatically reinstituted effective as of the date of loss of the coverage described above if You provide Us with notice of such loss within ninety (90) days.

Reinstitution of Coverage
If Your Coverage is reinstituted as stated above:

1. There will be no additional waiting period with respect to treatment of Pre-Existing Conditions;
2. Coverage will be substantially equivalent to Coverage in effect before the date of the suspension; and

3. Premium will be classified on terms that are at least as favorable to You as the Premium Classification terms that would have applied to You had the Coverage not been suspended.

Conversion Privilege
You may elect to convert Your Coverage under the group policy, without evidence of insurability, if:

1. The Policyholder terminates the group policy and does not replace it with another group Medicare Supplement Insurance policy; or
2. Your Coverage under the group policy terminates because You no longer meet the eligibility requirements provided under **Persons Eligible for Coverage** in this Section.

However, if Your Coverage terminates under the group policy because You failed to pay the required Premium for Your Coverage or You commit material misrepresentation, this conversion privilege will not be available to You.

Upon termination of Your Coverage under the group policy for the reasons stated above, We will notify You of:

1. Your right to convert Your Coverage provided under the group policy to an individual conversion policy; and
2. The policy(ies) being offered for conversion and the Premium applicable for the conversion policy.

You will have thirty-one (31) days from the date Your Coverage terminates under the group policy to apply and pay the required Premium for the conversion policy after Your Coverage terminates.

SECTION 4 – PREMIUMS

Payment of Premium
You must pay the Premium required for Your Coverage under the Certificate and remit such Premium directly to Us. After payment of the first (1st) billing, subsequent Premiums due will be drafted on or after the due date from Your bank account currently on file with Us. The Policyholder will not be responsible for the payment or contribution of any portion of the Premium required for Your Coverage. The Policyholder will not be responsible for collecting or remitting such Premium to Us.

Unpaid Premium
On payment of a claim under this Policy, any Premium then due and unpaid may be deducted from Your claim payment.

Grace Period
After You make the first Premium payment, if a subsequent Premium is not paid on or before the date it is due, You may pay the due Premium during the next ten (10) days. These ten (10) days are called the grace period. During the grace period, payment must be made to Our Home Office in the form of a cashier's check or money order (no personal checks, bank drafts, or cash accepted) or online by credit card. Your Coverage under the group policy will remain in force during the grace period. If any Premium is unpaid at the end of the grace period, Your Coverage under the group policy will automatically terminate retroactively to the paid-to date preceding the date You fail to pay the required Premium for Your Coverage under the group policy.

Premium Changes
You will have an attained age-rated adjustment each year with the first (1st) billing following Your birthday.

Subject to rate requirements applicable in the State of Tennessee, We may change the Premium for this Certificate at any time. Any Premium change will be made only when We change the Premium for all certificates in the same rate Class on the same form as this Certificate that are issued in the State of Tennessee. We will give You at least thirty (30) days prior written notice before the effective date of any Premium change. We will not change the Premium for this Certificate until such Premium change has been filed with and approved by the Tennessee Department of Commerce and Insurance, as applicable.

Premiums will never be changed due to a change in Your health, the number of claims You file, or Your type of work.

Please refer to Section 5, *Automatic Adjustment for Changes In Medicare Benefits,* for Premium changes required for benefit changes.

If the Premium is changed, Your continued payment of the new Premium for Your Coverage under the group policy will be considered as Your acceptance of the Premium change.

Premium Refund
In the event of Your death, We will refund any portion of the unearned Premium to Your estate.

Reinstatement
If the Premium is not paid before the grace period ends, the Certificate will lapse. Later acceptance of Premium by Us, without requiring an application for reinstatement, shall reinstate this Certificate. If We require an application for reinstatement, it must be submitted to Us. Reinstatement of the Certificate is subject to approval by Us. A reinstated Certificate will cover only loss from a Sickness that began or an Injury that occurred after the reinstatement. In all other respects Your rights and Our rights will remain the same as before the Certificate lapsed. You will be charged a reinstatement fee. Payment of the reinstatement fee and required Premium for the entire period Your Certificate had lapsed must be received by Us within ten (10) days of the final day of Your grace period to reinstate Your Certificate.

SECTION 5 – AUTOMATIC ADJUSTMENTS FOR CHANGES IN MEDICARE BENEFITS

The Medicare Supplement Insurance plans provided under the group policy are intended to cover the Deductible and Copayment or Coinsurance amounts imposed by Medicare. These amounts are cost sharing amounts under Medicare. The group policy will not duplicate the benefits provided by Medicare.

If Medicare changes any of its Part A or Part B Deductible amounts, Copayment amounts, Coinsurance amounts, or any other benefits covered by Medicare that are also covered under the plan provided under the group policy, the plan of the group policy will automatically be adjusted to coordinate with such Medicare changes. Any such change in benefits will take effect at the same time that the change in the Medicare program takes effect. A notification will be sent to the Policyholder and You of any Medicare benefit changes as required by state and/or federal regulation.

When such a benefit change occurs, the Premium may also be adjusted to correspond with the benefit changes. A Premium change will be subject to approval by the Tennessee Department of Commerce and Insurance.

Any change in Medicare coverage that becomes effective after Your Certificate Effective Date and causes a duplication of benefits will not void this Certificate.

SECTION 6 – PRE-EXISTING CONDITION LIMITATIONS

The group policy will not cover expenses due to a Pre-Existing Condition that You may have unless the expense is incurred six (6) months or more after Your Certificate Effective Date. A “Pre-Existing Condition” is a condition for which medical advice was given or treatment was recommended by or received from a Physician within six (6) months prior to Your Certificate Effective Date.

You must wait six (6) months from Your Certificate Effective Date before You can receive benefits for a Pre-Existing Condition under the group policy. However, the six (6) month Pre-Existing Condition Waiting Period may be waived or reduced in the following situations:

1. If, as of the date of Your Enrollment Application, You are in Medicare Open Enrollment and You had a Continuous Period of Creditable Coverage or had prior coverage for at least six (6) months, We will not exclude benefits based on a Pre-Existing Condition.
2. If, as of the date of Your Enrollment Application, You are in Medicare Open Enrollment and had a Continuous Period of Creditable Coverage or had prior coverage for less than six (6) months, We will reduce the period of the Pre-Existing Condition limitation by the time covered under such prior coverage.
3. If, as of the date of Your Enrollment Application, Your Coverage under the group policy replaced another Medicare Supplement Insurance plan, We will waive any time periods applicable to the Pre-Existing Condition limitation provision provided under this Certificate to the extent such time was spent under the prior policy or certificate.
4. If, as of the date of Your Enrollment Application, Your Coverage under the group policy replaced another Medicare Supplement Insurance policy or certificate which had been in effect for at least six (6) months, Your Coverage under the group policy will not apply the six (6) month Pre-Existing Condition limitation requirement.
5. If, as of the date of Your Enrollment Application, You qualified for Guaranteed Issue Coverage provided under the group policy, the six (6) month Pre-Existing Condition limitation will be waived.

SECTION 7 – EXCLUSIONS AND LIMITATIONS

The group policy does not provide benefits for:

1. Expenses incurred while the group policy or Your Coverage under the group policy is not in force;
2. Hospital or Skilled Nursing Facility Confinement expenses incurred by You during a Medicare Part A Benefit Period that begins while the group policy or Your Coverage under the group policy is not in force. However, Coverage for Your Medical Condition requiring the Confinement will be covered under the group policy on the earlier of: (a) the date the Confinement ends; or (b) six (6) months from Your Certificate Effective Date.

   However, this limitation will not apply if You meet the following requirements:

   a. You had a period of Creditable Coverage of at least six (6) months as of the date of Your Enrollment Application; and
   b. You are sixty-five (65) years of age or older; and
   c. You meet at least one (1) of the following:
      (1) You made application for Coverage under the group policy within six (6) months of attaining sixty-five (65) years of age; or
      (2) You enrolled within sixty-three (63) days following termination of coverage under a group health insurance plan; or
      (3) You enrolled within sixty-three (63) days of a Medicare Supplement Insurance policy or plan that terminated because: (a) the issuer became insolvent; (b) the issuer substantially violated a material provision of the Medicare Supplement Insurance policy or plan; or (c) the issuer or agent misrepresented the coverage to You when it was sold; or
      (4) You purchased Your Coverage under the group policy within sixty-three (63) days of Your disenrollment from a Medicare Risk HMO, Medicare Advantage HMO, PACE, or a Medicare Supplement Insurance Select policy or plan because:
         (a) Your prior carrier discontinued providing benefits to the service area;
         (b) You moved out of the service area; the carrier substantially violated a material provision of the policy or plan; or the issuer or agent materially misrepresented the Medicare Supplement Insurance plan to you when it was sold; or
         (c) other reasons specified by Health and Human Services (HHS).
3. Services and supplies which are not Medicare-Eligible Expenses, unless specifically included in the group policy;
4. Any expense payable by Medicare, whether or not You are enrolled for Medicare;

5. Any Medicare Deductible or Copayment/Coinsurance not included as a covered benefit under the group policy;
6. Services for which a charge is not normally made in the absence of insurance; or
7. Expenses for benefits that are not covered under the group policy; or
8. Any Insured enrolled in a Medicare Advantage Plan.

SECTION 8 – CLAIMS PROVISIONS

This section outlines terms and conditions applicable to filing, processing and payment of all claims, including those You file on Your behalf and those filed by a Provider on Your behalf. The vast majority of Medicare Supplement claims are filed directly by Providers.

Notice of Claim
You must give Us written notice of claim within twenty (20) days after the occurrence or commencement of any loss covered by the group policy or as soon as reasonably possible. Notice given by or on behalf of You or Your beneficiary to Us, with information sufficient to identify You will be deemed notice to Us.

Claim Forms
Upon receipt of notice of a claim, We will provide the claimant with the claim forms for filing proofs of loss. If We do not provide the claim forms within fifteen (15) days after the claimant provides Us with notice of the claim, the claimant will be deemed to have complied with the requirements of the group policy as to proof of loss upon submitting to Us, within the time fixed in the group policy for filing proof of loss, written proof of loss covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss
Written proof of loss must be completed and returned to Our Home Office at the address shown on the Schedule Declarations Page of this Certificate within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible. Except in the absence of legal capacity, no claim for benefits will be accepted after one (1) year from the time proof of loss is required.

Time Payment of Claims
Benefits payable under the group policy will be paid as indicated below in this provision.

Claims Filed By the Insured
If the claim is filed by You, We will pay or deny each Clean Claim within thirty (30) days after We receive written proof of loss from You.

Claims Filed By the Provider of Services
If the claim is filed by a Provider, We will pay or deny each Clean Claim received as follows:

1. If the claim is filed electronically, within twenty-one (21) days after the date the claim is received by Us.
2. If the claim is filed on paper, within thirty (30) days after the date the claim is received by Us.

We will notify a Provider of any deficiencies in a submitted claim and describe any remedy necessary to establish a Clean Claim not more than:

1. Twenty-one (21) days after filing for a claim that is filed electronically; or
2. Thirty (30) days after filing for a claim that is filed on paper;

Our failure to notify a Provider as required above, establishes the submitted claim as a Clean Claim.

Except for fraud, not more than eighteen (18) months after an overpayment on a Provider's claim was made to the Provider by Us, We may not:

1. Request the Provider to repay the overpayment; or

2. Adjust a subsequent claim filed by the Provider as a method of obtaining reimbursement of the overpayment from the Provider.

We may not be required to correct a payment error to a Provider more than eighteen (18) months after the date on which a payment on a Provider's claim was made to the Provider by Us.

Payment of Claims
Benefits payable under the group policy will be paid to You, unless We receive an assignment of benefits by You to pay Your health care Provider. Any benefits unpaid upon Your death will be paid to Your estate.

Claim Payments Paid Directly to Medicare Providers
We will pay claims directly to Medicare providers as follows:

1. We will accept a notice from a Medicare provider on dually assigned claims submitted by participating Physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice.
2. We will notify the participating Physician or supplier and the beneficiary of the payment determination.
3. We will pay the participating Physician or supplier directly.
4. We will furnish, at the time of Your enrollment under the group policy, a card listing the group policy name, number, Your Certificate number and a central mailing address to which notices from a Medicare carrier may be sent.
5. We will pay user fees for claim notices that are transmitted electronically or otherwise.

Physical Examinations and Autopsy
We, at Our own expense, will have the right and opportunity to examine You as often as We may reasonably require during the pendency of a claim under the group policy. In case of Your death, We, at Our own expense, may have an autopsy performed unless prohibited by law.

SECTION 9 – GENERAL PROVISIONS

Entire Contract
This Certificate, Your Application for this Certificate, any endorsements, riders and any attached papers constitute the entire contract. No change in this Certificate will be valid until approved by an executive officer of the Company and endorsed or attached to this Certificate.

Incontestability
Except for nonpayment of Premium, Your Coverage under the group policy cannot be contested if Your Coverage has been in force for two (2) years from Your Certificate Effective Date. No statement made by You relating to Your insurability may be used in contesting the validity of Your insurance Coverage under the group policy with respect to which the statement was made, unless: (1) the insurance Coverage under the group policy has not been in force for a period of two (2) years or longer during Your lifetime; or (2) the statement is contained in a written instrument signed by You.

Representations
In the absence of fraud, all statements made by You are deemed representations and not warranties. No statement made by You may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to You or, in the event of Your death or incapacity, to Your beneficiary or personal representative.

Evidence of Insurability
We reserve the right to require individual evidence of insurability as a condition of Coverage under the group policy except during applicable Medicare Open Enrollment or Guaranteed Issue Coverage time periods.

Nonparticipating
The group policy does not share in any distribution of surplus. No dividends are payable.

Certificate
We will issue a Certificate to all members of the Tennessee Farm Bureau enrolled under the group policy. The Certificate will explain the Coverage provided and the benefits payable under the group policy. It will also explain to whom benefits are payable.

Assignment of This Certificate
This Certificate cannot be assigned.

Misstatement of Age
If Your age has been misstated in the Enrollment Application, We will adjust the Premium to reflect the amount that should have been paid based on Your correct age. If Your age has been misstated in the Enrollment Application and, if based on Your correct age this Medicare Supplement Insurance plan would not have been issued, We will refund Premium paid, less the amount of any claims paid, and the Certificate will be considered never to have been issued.

Legal Actions
No legal action may be brought against Us to recover benefits:

1. Prior to the expiration of sixty (60) days after written proof of loss has been furnished to Us in accordance with the proof of loss provision in this Certificate; or
2. After the expiration of five (5) years after the time written proof of loss is required to be furnished to Us.

Other Insurance with Us
You can only be insured under one (1) of the Medicare Supplement Insurance plans provided under the group policy at any one (1) time. If You are insured under more than one (1) such Medicare Supplement Insurance plan under the group policy, You may select the one (1) plan that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return all Premiums paid from the date of Your death to the paid-to date (less any claims paid) for any Certificate of the Insured that does not remain in effect.

Certificateholder's Address
It is Your responsibility to maintain Your current address on file with Us at all times. All notices will be mailed to You at the address last shown in Our records.

Conformity with State Laws
Any provision of this Certificate, which, on its Certificate Effective Date, is in conflict with the laws of the State of Tennessee on that date, is amended to conform to the minimum requirements of such laws.

GROUP MEDICARE SUPPLEMENT INSURANCE CERTIFICATE
PLAN G

Guaranteed Renewable
Nonparticipating