



2020

# Medicare Supplement Plans

WEST VIRGINIA & OHIO ENROLLMENT GUIDE

FORM # OH: MS19EG  
WV: MS19EG

1110 Main Street  
Wheeling, WV 26003  
**1.877.847.7915 (TTY: 711)**  
**[healthplan.org](http://healthplan.org)**



# Table of Contents

1 – 3	Introduction
4 – 5	How to Enroll
6 – 7	Outline of Medicare Supplement Plan Coverage
8 – 69	Premium Information
70 – 73	Benefit Plan Summaries
74 – 79	Guaranteed Issue Guide
81	Nondiscrimination Statement



## We are pleased that you are considering us for your Medicare Supplement Plan.

We invite you to learn more by reading this enrollment guide. Inside this all-in-one booklet, you will find much of the information that you need as you consider your health care coverage options.

### **Locally owned and operated since**

**1979**, we provide prompt, personal, and reliable service to our members. We are easy to find, with offices and customer service call centers located in West Virginia and Ohio. We offer Medicare Supplement Plans A, C, D, F, F High Deductible, G, G High Deductible, and N.

**May we help you get started?** Call 1.877.847.7915 (TTY: 711). Our hours of operation are October 1 through March 31: 8:00 a.m. to 8:00 p.m., 7 days a week and April 1 through September 30: 8:00 a.m. to 8:00 p.m., Monday through Friday.



# Understanding the Parts of Medicare



## Medicare Part A

Helps cover the following:

- Inpatient care in hospitals
- Inpatient care in a skilled nursing facility (not custodial or long-term care)
- Hospice care services
- Inpatient care in a religious non-medical health care institution



## Medicare Part B

Helps cover the following:

- Doctor's services
- Testing
- Outpatient care
- Home health services
- Durable medical equipment
- Some preventive services
- Other medical services



## Medicare Supplement Insurance

Original Medicare pays for many of your health care services and supplies, but it doesn't pay for everything. That is why you may want to consider getting a Medicare Supplement insurance plan. A Medicare Supplement plan is sold by private insurance companies. These plans help pay some of the hospital and medical costs that Original Medicare doesn't cover. A Medicare Supplement plan helps to fill in the "gaps" in Original Medicare coverage, which is why it is also called "Medigap" insurance.

If you have Original Medicare and a Medicare Supplement plan, Medicare will pay first, as your primary insurance. Your Medicare Supplement plan will pay second, as your secondary insurance. (Please note: This may be different if you are covered under an employer group plan). A Medicare Supplement plan covers one person. If you and your spouse both want Medicare Supplement coverage, you'll each need to buy separate, individual policies.

### **Here are a few advantages to choosing Medicare Supplement coverage:**

- Medicare Supplement policies give you predictable out-of-pocket costs. With a Medicare Supplement, you can easily plan for what your out-of-pocket costs will be for the year.
- Medicare Supplement plans are standardized plans. This means that the core medical benefits are determined by the Federal Government, not the insurance company. This also means that those benefits generally do not change each year.
- Coverage can only be cancelled for non-payment of your monthly premium or material misrepresentation. Coverage cannot be cancelled due to your health changing.

**Give THP Insurance Company a call today at 1.877.847.7915. We can help you choose a plan that will meet your needs now, and in the future.**

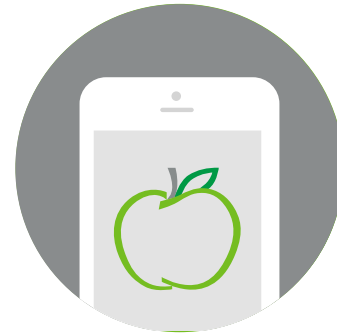


# How to Enroll



## In-Person

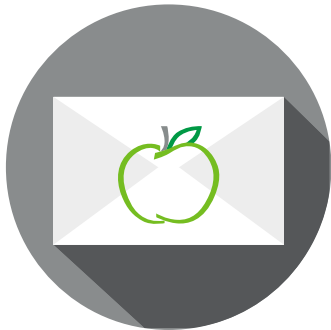
We have representatives available to assist you in-person with your enrollment. Please call **1.877.847.7915 (TTY: 711)** for more information. Our hours of operation are October 1 through March 31: 8:00 a.m. to 8:00 p.m., 7 days a week and April 1 through September 30: 8:00 a.m. to 8:00 p.m., Monday through Friday.



## By Phone

Please call **1.877.847.7915** to discuss your telephonic enrollment options with THP Insurance Company.

Enrolling is easy. Once you choose a plan,  
select the enrollment method  
that works best for you.



## By Mail

Complete and return the enclosed enrollment form. Complete an enrollment form for EACH PERSON enrolling. Be sure to indicate which plan you would like to enroll in. Mail all necessary forms in the postage-paid envelope included with this guide, or to: **The Health Plan, 1110 Main Street, Wheeling, WV 26003.**



## Online

Go to **[www.healthplan.org/medicare-supplement](http://www.healthplan.org/medicare-supplement)** to view your online enrollment options with THP Insurance Company.

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This document may be available in other formats such as braille, large print or other alternate formats. For additional information, please contact our customer service number at **1.877.847.7915**.



# West Virginia & Ohio Outline

Benefit plans A, C, D, F, High Deductible F, G, High Deductible G, and N are available from THP (see below)

Columns in gray are the Medicare Supplement Plans not available from THP Insurance Company.

Plan A	Plan B	Plan C	Plan D	Plan F/F*
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible
				Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency

\* Plan F has an option called a high-deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,340. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2,340. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B but do not include the plans separate foreign travel emergency deductible.



# Outline of Medicare Supplement Plan Coverage

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make plan "A" available. Some plans may not be available in your state. See Outline of Coverage sections for details about all plans.

## Basic Benefits

### Hospitalization

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

### Medical Expenses

Part B coinsurance (generally 20% of Medicare-approved expenses), or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.

### Blood

First 3 pints of blood each year

### Hospice

Part A coinsurance

Plan G/G**	Plan K	Plan L	Plan M	Plan N
Basic, including 100% Part B coinsurance**	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
Part B Excess (100%)				
Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
	Out-of Pocket limit \$5,880; paid at 100% after limit reached	Out-of Pocket limit \$2,940; paid at 100% after limit reached		

\*\* Plan G also offers a high-deductible plan. This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2,340 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2,340. 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.

# Monthly Premium Rates

## Region 1

OH counties: Portage, Summit

MALE	AGE	Plan A	Plan C	Plan D	Plan F	Plan FHD	Plan G	Plan GHD	Plan N
	65	\$105.58	\$150.89	\$129.74	\$150.98	\$59.50	\$129.83	\$59.50	\$116.63
	66	\$110.88	\$159.72	\$137.44	\$159.81	\$62.78	\$137.53	\$62.78	\$123.64
	67	\$116.18	\$168.55	\$145.13	\$168.65	\$66.06	\$145.23	\$66.06	\$130.65
	68	\$121.48	\$177.38	\$152.83	\$177.49	\$69.34	\$152.93	\$69.34	\$137.65
	69	\$126.78	\$186.21	\$160.53	\$186.32	\$72.61	\$160.63	\$72.61	\$144.66
	70	\$132.07	\$195.04	\$168.23	\$195.16	\$75.89	\$168.34	\$75.89	\$151.67
	71	\$137.37	\$203.87	\$175.92	\$203.99	\$79.17	\$176.04	\$79.17	\$158.68
	72	\$142.67	\$212.71	\$183.62	\$212.83	\$82.45	\$183.74	\$82.45	\$165.69
	73	\$147.64	\$222.64	\$192.46	\$222.77	\$86.14	\$192.59	\$86.14	\$173.89
	74	\$152.62	\$232.58	\$201.31	\$232.71	\$89.83	\$201.43	\$89.83	\$182.09
	75	\$157.59	\$242.52	\$210.15	\$242.65	\$93.52	\$210.28	\$93.52	\$190.30
	76	\$162.57	\$252.45	\$218.99	\$252.60	\$97.20	\$219.13	\$97.20	\$198.50
	77	\$167.54	\$262.39	\$227.83	\$262.54	\$100.89	\$227.97	\$100.89	\$206.70
	78	\$171.01	\$272.61	\$237.22	\$272.76	\$104.68	\$237.36	\$104.68	\$215.66
	79	\$174.48	\$282.82	\$246.61	\$282.97	\$108.48	\$246.76	\$108.48	\$224.61
	80	\$177.96	\$293.04	\$256.00	\$293.19	\$112.27	\$256.15	\$112.27	\$233.57
	81	\$181.43	\$303.25	\$265.39	\$303.41	\$116.06	\$265.54	\$116.06	\$242.53
	82	\$184.90	\$313.47	\$274.78	\$313.63	\$119.85	\$274.93	\$119.85	\$251.48
	83	\$187.78	\$334.11	\$294.51	\$334.27	\$127.51	\$294.66	\$127.51	\$270.91
	84	\$190.67	\$354.76	\$314.24	\$354.91	\$135.17	\$314.39	\$135.17	\$290.33
	85+	\$193.56	\$375.40	\$333.97	\$375.56	\$142.83	\$334.13	\$142.83	\$309.75



We, THP Insurance Company can only raise your premium if we raise the premium for all policies in this state. Your premium is determined upon your gender and attained age. Your premium will change each year based upon your attained age on the date of your plan renewal, January 1.

After the first one month's payments, the term of this coverage is for one month if you have chosen monthly premium payments. If you prepay this coverage on a quarterly, semi-annual or annual basis, the term of the coverage will be the period prepaid. The policy renews automatically, subject to the right of THP Insurance Company to change premium charges.

## FEMALE

AGE	Plan A	Plan C	Plan D	Plan F	Plan FHD	Plan G	Plan GHD	Plan N
65	\$111.75	\$155.10	\$132.74	\$155.20	\$61.07	\$132.84	\$61.07	\$118.81
66	\$115.45	\$162.17	\$139.01	\$162.27	\$63.69	\$139.10	\$63.69	\$124.59
67	\$119.15	\$169.24	\$145.27	\$169.35	\$66.32	\$145.37	\$66.32	\$130.38
68	\$122.85	\$176.32	\$151.53	\$176.42	\$68.94	\$151.64	\$68.94	\$136.16
69	\$126.56	\$183.39	\$157.80	\$183.50	\$71.57	\$157.90	\$71.57	\$141.95
70	\$130.26	\$190.46	\$164.06	\$190.57	\$74.19	\$164.17	\$74.19	\$147.74
71	\$133.96	\$197.53	\$170.32	\$197.65	\$76.82	\$170.43	\$76.82	\$153.52
72	\$137.66	\$204.60	\$176.59	\$204.72	\$79.44	\$176.70	\$79.44	\$159.31
73	\$140.81	\$212.56	\$183.82	\$212.68	\$82.40	\$183.94	\$82.40	\$166.14
74	\$143.95	\$220.52	\$191.05	\$220.64	\$85.35	\$191.17	\$85.35	\$172.98
75	\$147.10	\$228.47	\$198.29	\$228.60	\$88.30	\$198.41	\$88.30	\$179.81
76	\$150.25	\$236.43	\$205.52	\$236.56	\$91.26	\$205.64	\$91.26	\$186.65
77	\$153.40	\$244.39	\$212.75	\$244.52	\$94.21	\$212.88	\$94.21	\$193.48
78	\$155.74	\$253.55	\$221.31	\$253.68	\$97.61	\$221.44	\$97.61	\$201.76
79	\$158.09	\$262.71	\$229.87	\$262.84	\$101.01	\$230.00	\$101.01	\$210.03
80	\$160.44	\$271.86	\$238.43	\$272.00	\$104.40	\$238.56	\$104.40	\$218.31
81	\$162.78	\$281.02	\$246.98	\$281.16	\$107.80	\$247.12	\$107.80	\$226.58
82	\$165.13	\$290.18	\$255.54	\$290.32	\$111.20	\$255.68	\$111.20	\$234.86
83	\$165.56	\$308.97	\$273.91	\$309.11	\$118.17	\$274.04	\$118.17	\$253.24
84	\$165.99	\$327.77	\$292.27	\$327.90	\$125.15	\$292.40	\$125.15	\$271.63
85+	\$166.43	\$346.56	\$310.64	\$346.70	\$132.12	\$310.76	\$132.12	\$290.01

# Monthly Premium Rates

## Region 2

OH counties: Carroll, Stark

MALE	AGE	Plan A	Plan C	Plan D	Plan F	Plan FHD	Plan G	Plan GHD	Plan N
	65	\$105.64	\$149.28	\$128.20	\$149.37	\$58.89	\$128.29	\$58.89	\$114.62
	66	\$110.90	\$157.91	\$135.71	\$158.02	\$62.10	\$135.81	\$62.10	\$121.42
	67	\$116.16	\$166.55	\$143.22	\$166.66	\$65.31	\$143.32	\$65.31	\$128.22
	68	\$121.43	\$175.19	\$150.73	\$175.30	\$68.51	\$150.84	\$68.51	\$135.02
	69	\$126.69	\$183.83	\$158.25	\$183.94	\$71.72	\$158.36	\$71.72	\$141.82
	70	\$131.95	\$192.46	\$165.76	\$192.59	\$74.93	\$165.87	\$74.93	\$148.62
	71	\$137.21	\$201.10	\$173.27	\$201.23	\$78.13	\$173.39	\$78.13	\$155.42
	72	\$142.47	\$209.74	\$180.78	\$209.87	\$81.34	\$180.91	\$81.34	\$162.22
	73	\$147.35	\$219.33	\$189.30	\$219.47	\$84.90	\$189.43	\$84.90	\$170.08
	74	\$152.23	\$228.93	\$197.81	\$229.07	\$88.47	\$197.95	\$88.47	\$177.94
	75	\$157.11	\$238.53	\$206.33	\$238.67	\$92.03	\$206.47	\$92.03	\$185.80
	76	\$161.99	\$248.12	\$214.85	\$248.27	\$95.59	\$214.99	\$95.59	\$193.66
	77	\$166.87	\$257.72	\$223.36	\$257.88	\$99.15	\$223.51	\$99.15	\$201.52
	78	\$170.16	\$267.38	\$232.22	\$267.54	\$102.74	\$232.37	\$102.74	\$209.94
	79	\$173.45	\$277.04	\$241.08	\$277.20	\$106.32	\$241.24	\$106.32	\$218.36
	80	\$176.74	\$286.71	\$249.94	\$286.87	\$109.91	\$250.10	\$109.91	\$226.78
	81	\$180.03	\$296.37	\$258.80	\$296.53	\$113.50	\$258.96	\$113.50	\$235.21
	82	\$183.31	\$306.03	\$267.66	\$306.20	\$117.08	\$267.82	\$117.08	\$243.63
	83	\$185.62	\$325.04	\$285.84	\$325.21	\$124.14	\$286.00	\$124.14	\$261.51
	84	\$187.92	\$344.06	\$304.01	\$344.23	\$131.19	\$304.17	\$131.19	\$279.40
	85+	\$190.22	\$363.07	\$322.18	\$363.24	\$138.25	\$322.34	\$138.25	\$297.29

We, THP Insurance Company can only raise your premium if we raise the premium for all policies in this state. Your premium is determined upon your gender and attained age. Your premium will change each year based upon your attained age on the date of your plan renewal, January 1.

After the first one month's payments, the term of this coverage is for one month if you have chosen monthly premium payments. If you prepay this coverage on a quarterly, semi-annual or annual basis, the term of the coverage will be the period prepaid. The policy renews automatically, subject to the right of THP Insurance Company to change premium charges.

FEMALE	AGE	Plan A	Plan C	Plan D	Plan F	Plan FHD	Plan G	Plan GHD	Plan N
	65	\$111.98	\$153.85	\$131.55	\$153.95	\$60.59	\$131.65	\$60.59	\$117.10
	66	\$115.63	\$160.70	\$137.60	\$160.80	\$63.14	\$137.70	\$63.14	\$122.66
	67	\$119.27	\$167.55	\$143.65	\$167.66	\$65.68	\$143.75	\$65.68	\$128.22
	68	\$122.91	\$174.40	\$149.70	\$174.51	\$68.22	\$149.81	\$68.22	\$133.78
	69	\$126.56	\$181.25	\$155.75	\$181.36	\$70.76	\$155.86	\$70.76	\$139.34
	70	\$130.20	\$188.09	\$161.80	\$188.22	\$73.31	\$161.91	\$73.31	\$144.90
	71	\$133.84	\$194.94	\$167.85	\$195.07	\$75.85	\$167.97	\$75.85	\$150.46
	72	\$137.48	\$201.79	\$173.90	\$201.92	\$78.39	\$174.02	\$78.39	\$156.01
	73	\$140.51	\$209.37	\$180.77	\$209.51	\$81.21	\$180.90	\$81.21	\$162.48
	74	\$143.54	\$216.96	\$187.65	\$217.09	\$84.02	\$187.77	\$84.02	\$168.95
	75	\$146.57	\$224.54	\$194.52	\$224.67	\$86.83	\$194.65	\$86.83	\$175.42
	76	\$149.60	\$232.12	\$201.39	\$232.26	\$89.65	\$201.52	\$89.65	\$181.89
	77	\$152.63	\$239.70	\$208.27	\$239.84	\$92.46	\$208.40	\$92.46	\$188.35
	78	\$154.77	\$248.27	\$216.26	\$248.41	\$95.64	\$216.39	\$95.64	\$196.07
	79	\$156.91	\$256.83	\$224.25	\$256.98	\$98.82	\$224.39	\$98.82	\$203.78
	80	\$159.05	\$265.40	\$232.24	\$265.55	\$102.00	\$232.38	\$102.00	\$211.49
	81	\$161.20	\$273.97	\$240.24	\$274.11	\$105.18	\$240.38	\$105.18	\$219.20
	82	\$163.34	\$282.53	\$248.23	\$282.68	\$108.36	\$248.37	\$108.36	\$226.91
	83	\$163.12	\$299.57	\$264.91	\$299.72	\$114.68	\$265.05	\$114.68	\$243.65
	84	\$162.91	\$316.61	\$281.60	\$316.76	\$121.00	\$281.73	\$121.00	\$260.40
	85+	\$162.69	\$333.65	\$298.28	\$333.79	\$127.32	\$298.42	\$127.32	\$277.14

# Monthly Premium Rates

## Region 3

OH counties: Medina

### MALE

AGE	Plan A	Plan C	Plan D	Plan F	Plan FHD	Plan G	Plan GHD	Plan N
65	\$115.37	\$163.11	\$141.43	\$163.20	\$64.05	\$141.52	\$64.05	\$127.00
66	\$121.16	\$172.66	\$149.82	\$172.76	\$67.60	\$149.91	\$67.60	\$134.63
67	\$126.96	\$182.21	\$158.21	\$182.32	\$71.14	\$158.31	\$71.14	\$142.26
68	\$132.76	\$191.76	\$166.59	\$191.87	\$74.69	\$166.70	\$74.69	\$149.89
69	\$138.56	\$201.32	\$174.98	\$201.43	\$78.24	\$175.09	\$78.24	\$157.52
70	\$144.35	\$210.87	\$183.37	\$210.99	\$81.78	\$183.48	\$81.78	\$165.15
71	\$150.15	\$220.42	\$191.76	\$220.55	\$85.33	\$191.88	\$85.33	\$172.78
72	\$155.95	\$229.97	\$200.14	\$230.10	\$88.87	\$200.27	\$88.87	\$180.41
73	\$161.36	\$240.69	\$209.73	\$240.83	\$92.85	\$209.86	\$92.85	\$189.29
74	\$166.77	\$251.41	\$219.32	\$251.55	\$96.83	\$219.46	\$96.83	\$198.18
75	\$172.18	\$262.13	\$228.91	\$262.27	\$100.81	\$229.05	\$100.81	\$207.06
76	\$177.60	\$272.85	\$238.50	\$272.99	\$104.79	\$238.64	\$104.79	\$215.95
77	\$183.01	\$283.56	\$248.09	\$283.72	\$108.77	\$248.24	\$108.77	\$224.84
78	\$186.72	\$294.53	\$258.20	\$294.69	\$112.84	\$258.35	\$112.84	\$234.47
79	\$190.44	\$305.50	\$268.31	\$305.65	\$116.91	\$268.46	\$116.91	\$244.11
80	\$194.15	\$316.46	\$278.42	\$316.62	\$120.98	\$278.57	\$120.98	\$253.74
81	\$197.86	\$327.43	\$288.52	\$327.59	\$125.05	\$288.68	\$125.05	\$263.38
82	\$201.58	\$338.40	\$298.63	\$338.56	\$129.12	\$298.79	\$129.12	\$273.01
83	\$204.43	\$360.43	\$319.69	\$360.59	\$137.29	\$319.85	\$137.29	\$293.74
84	\$207.29	\$382.46	\$340.75	\$382.63	\$145.47	\$340.91	\$145.47	\$314.47
85+	\$210.14	\$404.50	\$361.81	\$404.66	\$153.64	\$361.97	\$153.64	\$335.20

We, THP Insurance Company can only raise your premium if we raise the premium for all policies in this state. Your premium is determined upon your gender and attained age. Your premium will change each year based upon your attained age on the date of your plan renewal, January 1.

After the first one month's payments, the term of this coverage is for one month if you have chosen monthly premium payments. If you prepay this coverage on a quarterly, semi-annual or annual basis, the term of the coverage will be the period prepaid. The policy renews automatically, subject to the right of THP Insurance Company to change premium charges.

FEMALE	AGE	Plan A	Plan C	Plan D	Plan F	Plan FHD	Plan G	Plan GHD	Plan N
	65	\$122.23	\$167.78	\$144.87	\$167.88	\$65.79	\$144.97	\$65.79	\$129.53
	66	\$126.26	\$175.41	\$151.67	\$175.52	\$68.62	\$151.78	\$68.62	\$135.80
	67	\$130.30	\$183.04	\$158.47	\$183.15	\$71.45	\$158.58	\$71.45	\$142.08
	68	\$134.33	\$190.67	\$165.27	\$190.79	\$74.29	\$165.38	\$74.29	\$148.35
	69	\$138.36	\$198.31	\$172.07	\$198.42	\$77.12	\$172.18	\$77.12	\$154.63
	70	\$142.39	\$205.94	\$178.87	\$206.06	\$79.95	\$178.99	\$79.95	\$160.90
	71	\$146.43	\$213.57	\$185.67	\$213.69	\$82.79	\$185.79	\$82.79	\$167.18
	72	\$150.46	\$221.20	\$192.47	\$221.33	\$85.62	\$192.59	\$85.62	\$173.45
	73	\$153.85	\$229.76	\$200.28	\$229.89	\$88.79	\$200.40	\$88.79	\$180.82
	74	\$157.25	\$238.32	\$208.08	\$238.45	\$91.97	\$208.21	\$91.97	\$188.19
	75	\$160.64	\$246.87	\$215.89	\$247.01	\$95.15	\$216.02	\$95.15	\$195.56
	76	\$164.03	\$255.43	\$223.70	\$255.57	\$98.32	\$223.83	\$98.32	\$202.93
	77	\$167.42	\$263.99	\$231.50	\$264.13	\$101.50	\$231.64	\$101.50	\$210.30
	78	\$169.89	\$273.79	\$240.68	\$273.93	\$105.14	\$240.82	\$105.14	\$219.17
	79	\$172.36	\$283.60	\$249.86	\$283.74	\$108.78	\$250.00	\$108.78	\$228.05
	80	\$174.82	\$293.41	\$259.04	\$293.55	\$112.42	\$259.18	\$112.42	\$236.92
	81	\$177.29	\$303.22	\$268.22	\$303.36	\$116.05	\$268.36	\$116.05	\$245.79
	82	\$179.76	\$313.02	\$277.40	\$313.17	\$119.69	\$277.54	\$119.69	\$254.66
	83	\$179.88	\$333.01	\$296.91	\$333.16	\$127.11	\$297.05	\$127.11	\$274.20
	84	\$180.01	\$353.00	\$316.42	\$353.14	\$134.53	\$316.55	\$134.53	\$293.74
	85+	\$180.14	\$373.00	\$335.93	\$373.13	\$141.94	\$336.06	\$141.94	\$313.29

# Monthly Premium Rates

## Region 4

OH counties: Jefferson; WV counties: Brooke, Hancock

MALE	AGE	Plan A	Plan C	Plan D	Plan F	Plan FHD	Plan G	Plan GHD	Plan N
	65	\$122.10	\$171.50	\$149.47	\$171.62	\$67.22	\$149.57	\$67.22	\$133.48
	66	\$128.28	\$181.59	\$158.36	\$181.70	\$70.96	\$158.47	\$70.96	\$141.53
	67	\$134.46	\$191.67	\$167.25	\$191.79	\$74.70	\$167.37	\$74.70	\$149.59
	68	\$140.64	\$201.75	\$176.15	\$201.87	\$78.45	\$176.27	\$78.45	\$157.64
	69	\$146.82	\$211.83	\$185.04	\$211.96	\$82.19	\$185.17	\$82.19	\$165.69
	70	\$153.00	\$221.91	\$193.93	\$222.05	\$85.93	\$194.06	\$85.93	\$173.75
	71	\$159.18	\$231.99	\$202.82	\$232.13	\$89.67	\$202.96	\$89.67	\$181.80
	72	\$165.36	\$242.07	\$211.72	\$242.22	\$93.41	\$211.86	\$93.41	\$189.86
	73	\$171.16	\$253.41	\$221.90	\$253.56	\$97.62	\$222.05	\$97.62	\$199.26
	74	\$176.97	\$264.74	\$232.08	\$264.90	\$101.83	\$232.23	\$101.83	\$208.66
	75	\$182.77	\$276.08	\$242.26	\$276.25	\$106.04	\$242.42	\$106.04	\$218.07
	76	\$188.58	\$287.42	\$252.44	\$287.59	\$110.25	\$252.61	\$110.25	\$227.47
	77	\$194.38	\$298.75	\$262.62	\$298.93	\$114.46	\$262.79	\$114.46	\$236.87
	78	\$198.44	\$310.40	\$273.38	\$310.58	\$118.78	\$273.55	\$118.78	\$247.11
	79	\$202.50	\$322.04	\$284.14	\$322.22	\$123.10	\$284.31	\$123.10	\$257.35
	80	\$206.55	\$333.68	\$294.89	\$333.87	\$127.42	\$295.07	\$127.42	\$267.58
	81	\$210.61	\$345.33	\$305.65	\$345.51	\$131.74	\$305.83	\$131.74	\$277.82
	82	\$214.67	\$356.97	\$316.41	\$357.16	\$136.06	\$316.59	\$136.06	\$288.05
	83	\$218.06	\$380.47	\$338.87	\$380.67	\$144.78	\$339.06	\$144.78	\$310.17
	84	\$221.45	\$403.98	\$361.34	\$404.17	\$153.50	\$361.52	\$153.50	\$332.28
	85+	\$224.84	\$427.48	\$383.81	\$427.67	\$162.23	\$383.99	\$162.23	\$354.40





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After the first one month's payments, the term of this coverage is for one month if you have chosen monthly premium payments. If you prepay this coverage on a quarterly, semi-annual or annual basis, the term of the coverage will be the period prepaid. The policy renews automatically, subject to the right of THP Insurance Company to change premium charges.

FEMALE	AGE	Plan A	Plan C	Plan D	Plan F	Plan FHD	Plan G	Plan GHD	Plan N
	65	\$129.28	\$176.34	\$153.07	\$176.46	\$69.01	\$153.18	\$69.01	\$136.06
	66	\$133.60	\$184.41	\$160.28	\$184.53	\$72.01	\$160.40	\$72.01	\$142.70
	67	\$137.92	\$192.47	\$167.50	\$192.60	\$75.00	\$167.62	\$75.00	\$149.34
	68	\$142.24	\$200.54	\$174.72	\$200.67	\$78.00	\$174.84	\$78.00	\$155.97
	69	\$146.56	\$208.61	\$181.93	\$208.75	\$80.99	\$182.06	\$80.99	\$162.61
	70	\$150.88	\$216.68	\$189.15	\$216.82	\$83.99	\$189.28	\$83.99	\$169.25
	71	\$155.20	\$224.75	\$196.37	\$224.89	\$86.99	\$196.50	\$86.99	\$175.88
	72	\$159.52	\$232.82	\$203.58	\$232.96	\$89.98	\$203.72	\$89.98	\$182.52
	73	\$163.19	\$241.89	\$211.88	\$242.04	\$93.35	\$212.03	\$93.35	\$190.34
	74	\$166.87	\$250.96	\$220.19	\$251.12	\$96.72	\$220.33	\$96.72	\$198.16
	75	\$170.54	\$260.04	\$228.49	\$260.19	\$100.08	\$228.63	\$100.08	\$205.98
	76	\$174.22	\$269.11	\$236.79	\$269.27	\$103.45	\$236.94	\$103.45	\$213.80
	77	\$177.89	\$278.18	\$245.09	\$278.34	\$106.82	\$245.24	\$106.82	\$221.62
	78	\$180.64	\$288.62	\$254.87	\$288.78	\$110.69	\$255.02	\$110.69	\$231.06
	79	\$183.38	\$299.05	\$264.64	\$299.21	\$114.56	\$264.80	\$114.56	\$240.50
	80	\$186.13	\$309.48	\$274.42	\$309.65	\$118.43	\$274.58	\$118.43	\$249.94
	81	\$188.87	\$319.92	\$284.20	\$320.08	\$122.31	\$284.36	\$122.31	\$259.38
	82	\$191.62	\$330.35	\$293.98	\$330.52	\$126.18	\$294.14	\$126.18	\$268.82
	83	\$192.15	\$351.73	\$314.82	\$351.90	\$134.11	\$314.98	\$134.11	\$289.72
	84	\$192.68	\$373.12	\$335.66	\$373.28	\$142.04	\$335.82	\$142.04	\$310.61
	85+	\$193.21	\$394.50	\$356.51	\$394.66	\$149.98	\$356.66	\$149.98	\$331.50

# Monthly Premium Rates

## Region 5

OH counties: Belmont; WV counties: Marshall, Ohio

MALE	AGE	Plan A	Plan C	Plan D	Plan F	Plan FHD	Plan G	Plan GHD	Plan N
	65	\$109.44	\$153.02	\$131.78	\$153.11	\$60.34	\$131.86	\$60.34	\$117.97
	66	\$114.91	\$161.85	\$139.47	\$161.94	\$63.62	\$139.56	\$63.62	\$124.95
	67	\$120.38	\$170.67	\$147.17	\$170.78	\$66.90	\$147.26	\$66.90	\$131.92
	68	\$125.85	\$179.50	\$154.86	\$179.61	\$70.17	\$154.96	\$70.17	\$138.89
	69	\$131.32	\$188.33	\$162.56	\$188.44	\$73.45	\$162.66	\$73.45	\$145.86
	70	\$136.79	\$197.16	\$170.25	\$197.28	\$76.73	\$170.36	\$76.73	\$152.84
	71	\$142.26	\$205.99	\$177.95	\$206.11	\$80.01	\$178.07	\$80.01	\$159.81
	72	\$147.73	\$214.82	\$185.64	\$214.95	\$83.28	\$185.77	\$83.28	\$166.78
	73	\$152.82	\$224.59	\$194.33	\$224.73	\$86.91	\$194.46	\$86.91	\$174.80
	74	\$157.91	\$234.37	\$203.02	\$234.50	\$90.54	\$203.15	\$90.54	\$182.82
	75	\$163.00	\$244.14	\$211.70	\$244.28	\$94.17	\$211.84	\$94.17	\$190.84
	76	\$168.09	\$253.92	\$220.39	\$254.06	\$97.80	\$220.53	\$97.80	\$198.86
	77	\$173.18	\$263.69	\$229.08	\$263.84	\$101.43	\$229.22	\$101.43	\$206.88
	78	\$176.64	\$273.48	\$238.05	\$273.63	\$105.06	\$238.20	\$105.06	\$215.41
	79	\$180.09	\$283.26	\$247.03	\$283.41	\$108.69	\$247.17	\$108.69	\$223.94
	80	\$183.55	\$293.04	\$256.00	\$293.19	\$112.32	\$256.15	\$112.32	\$232.47
	81	\$187.01	\$302.82	\$264.98	\$302.98	\$115.95	\$265.13	\$115.95	\$241.00
	82	\$190.46	\$312.60	\$273.95	\$312.76	\$119.58	\$274.11	\$119.58	\$249.53
	83	\$192.99	\$331.70	\$292.21	\$331.86	\$126.67	\$292.36	\$126.67	\$267.49
	84	\$195.51	\$350.80	\$310.46	\$350.96	\$133.75	\$310.61	\$133.75	\$285.46
	85+	\$198.03	\$369.90	\$328.71	\$370.06	\$140.84	\$328.86	\$140.84	\$303.42



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After the first one month's payments, the term of this coverage is for one month if you have chosen monthly premium payments. If you prepay this coverage on a quarterly, semi-annual or annual basis, the term of the coverage will be the period prepaid. The policy renews automatically, subject to the right of THP Insurance Company to change premium charges.

FEMALE	AGE	Plan A	Plan C	Plan D	Plan F	Plan FHD	Plan G	Plan GHD	Plan N
	65	\$115.98	\$157.82	\$135.35	\$157.92	\$62.13	\$135.44	\$62.13	\$120.66
	66	\$119.78	\$164.80	\$141.52	\$164.90	\$64.72	\$141.62	\$64.72	\$126.34
	67	\$123.57	\$171.78	\$147.70	\$171.89	\$67.31	\$147.80	\$67.31	\$132.02
	68	\$127.37	\$178.77	\$153.88	\$178.87	\$69.90	\$153.98	\$69.90	\$137.70
	69	\$131.17	\$185.75	\$160.06	\$185.86	\$72.49	\$160.16	\$72.49	\$143.38
	70	\$134.96	\$192.73	\$166.23	\$192.85	\$75.08	\$166.34	\$75.08	\$149.05
	71	\$138.76	\$199.71	\$172.41	\$199.83	\$77.68	\$172.52	\$77.68	\$154.73
	72	\$142.55	\$206.69	\$178.59	\$206.82	\$80.27	\$178.70	\$80.27	\$160.41
	73	\$145.73	\$214.39	\$185.57	\$214.51	\$83.12	\$185.69	\$83.12	\$166.98
	74	\$148.90	\$222.08	\$192.55	\$222.20	\$85.98	\$192.67	\$85.98	\$173.55
	75	\$152.07	\$229.77	\$199.53	\$229.90	\$88.83	\$199.65	\$88.83	\$180.11
	76	\$155.24	\$237.46	\$206.50	\$237.59	\$91.69	\$206.63	\$91.69	\$186.68
	77	\$158.41	\$245.15	\$213.48	\$245.29	\$94.54	\$213.61	\$94.54	\$193.25
	78	\$160.69	\$253.80	\$221.55	\$253.93	\$97.75	\$221.68	\$97.75	\$201.03
	79	\$162.96	\$262.44	\$229.62	\$262.58	\$100.96	\$229.75	\$100.96	\$208.81
	80	\$165.23	\$271.09	\$237.69	\$271.23	\$104.17	\$237.82	\$104.17	\$216.60
	81	\$167.50	\$279.73	\$245.75	\$279.87	\$107.38	\$245.89	\$107.38	\$224.38
	82	\$169.77	\$288.38	\$253.82	\$288.52	\$110.58	\$253.95	\$110.58	\$232.16
	83	\$169.69	\$305.41	\$270.50	\$305.55	\$116.90	\$270.63	\$116.90	\$248.90
	84	\$169.62	\$322.44	\$287.17	\$322.58	\$123.22	\$287.30	\$123.22	\$265.64
	85+	\$169.55	\$339.47	\$303.85	\$339.61	\$129.54	\$303.98	\$129.54	\$282.38

# Monthly Premium Rates

## Region 6

OH counties: Mahoning, Trumbull

MALE	AGE	Plan A	Plan C	Plan D	Plan F	Plan FHD	Plan G	Plan GHD	Plan N
	65	\$115.58	\$163.23	\$141.54	\$163.33	\$64.11	\$141.65	\$64.11	\$126.33
	66	\$121.42	\$172.81	\$149.96	\$172.92	\$67.67	\$150.07	\$67.67	\$133.94
	67	\$127.25	\$182.39	\$158.38	\$182.51	\$71.23	\$158.49	\$71.23	\$141.56
	68	\$133.09	\$191.97	\$166.79	\$192.09	\$74.78	\$166.91	\$74.78	\$149.18
	69	\$138.93	\$201.55	\$175.21	\$201.68	\$78.34	\$175.33	\$78.34	\$156.79
	70	\$144.77	\$211.13	\$183.62	\$211.27	\$81.90	\$183.75	\$81.90	\$164.41
	71	\$150.60	\$220.72	\$192.04	\$220.86	\$85.46	\$192.17	\$85.46	\$172.03
	72	\$156.44	\$230.30	\$200.45	\$230.44	\$89.01	\$200.59	\$89.01	\$179.64
	73	\$161.93	\$241.08	\$210.10	\$241.23	\$93.02	\$210.25	\$93.02	\$188.55
	74	\$167.42	\$251.86	\$219.75	\$252.01	\$97.02	\$219.90	\$97.02	\$197.46
	75	\$172.92	\$262.64	\$229.40	\$262.80	\$101.02	\$229.55	\$101.02	\$206.37
	76	\$178.41	\$273.42	\$239.05	\$273.58	\$105.02	\$239.21	\$105.02	\$215.28
	77	\$183.90	\$284.20	\$248.70	\$284.37	\$109.02	\$248.86	\$109.02	\$224.19
	78	\$187.75	\$295.28	\$258.92	\$295.45	\$113.13	\$259.08	\$113.13	\$233.91
	79	\$191.60	\$306.36	\$269.13	\$306.53	\$117.25	\$269.30	\$117.25	\$243.63
	80	\$195.46	\$317.44	\$279.35	\$317.62	\$121.36	\$279.52	\$121.36	\$253.35
	81	\$199.31	\$328.52	\$289.57	\$328.70	\$125.47	\$289.74	\$125.47	\$263.07
	82	\$203.16	\$339.60	\$299.78	\$339.78	\$129.58	\$299.96	\$129.58	\$272.79
	83	\$206.44	\$361.99	\$321.18	\$362.17	\$137.89	\$321.36	\$137.89	\$293.86
	84	\$209.72	\$384.37	\$342.58	\$384.55	\$146.20	\$342.75	\$146.20	\$314.92
	85+	\$213.00	\$406.76	\$363.98	\$406.94	\$154.50	\$364.15	\$154.50	\$335.98

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After the first one month's payments, the term of this coverage is for one month if you have chosen monthly premium payments. If you prepay this coverage on a quarterly, semi-annual or annual basis, the term of the coverage will be the period prepaid. The policy renews automatically, subject to the right of THP Insurance Company to change premium charges.

FEMALE	AGE	Plan A	Plan C	Plan D	Plan F	Plan FHD	Plan G	Plan GHD	Plan N
	65	\$122.33	\$167.80	\$144.90	\$167.92	\$65.81	\$145.01	\$65.81	\$128.71
	66	\$126.42	\$175.47	\$151.74	\$175.59	\$68.66	\$151.85	\$68.66	\$135.00
	67	\$130.50	\$183.15	\$158.57	\$183.27	\$71.51	\$158.69	\$71.51	\$141.28
	68	\$134.59	\$190.82	\$165.41	\$190.94	\$74.36	\$165.53	\$74.36	\$147.57
	69	\$138.67	\$198.49	\$172.25	\$198.62	\$77.21	\$172.37	\$77.21	\$153.85
	70	\$142.75	\$206.16	\$179.09	\$206.29	\$80.05	\$179.21	\$80.05	\$160.14
	71	\$146.84	\$213.83	\$185.92	\$213.97	\$82.90	\$186.05	\$82.90	\$166.42
	72	\$150.92	\$221.51	\$192.76	\$221.65	\$85.75	\$192.89	\$85.75	\$172.71
	73	\$154.41	\$230.14	\$200.64	\$230.28	\$88.95	\$200.77	\$88.95	\$180.13
	74	\$157.89	\$238.77	\$208.52	\$238.91	\$92.16	\$208.66	\$92.16	\$187.55
	75	\$161.38	\$247.40	\$216.39	\$247.55	\$95.36	\$216.54	\$95.36	\$194.97
	76	\$164.86	\$256.03	\$224.27	\$256.18	\$98.56	\$224.42	\$98.56	\$202.39
	77	\$168.35	\$264.66	\$232.15	\$264.82	\$101.77	\$232.30	\$101.77	\$209.81
	78	\$170.97	\$274.60	\$241.45	\$274.75	\$105.45	\$241.60	\$105.45	\$218.79
	79	\$173.58	\$284.53	\$250.75	\$284.68	\$109.14	\$250.90	\$109.14	\$227.76
	80	\$176.20	\$294.46	\$260.05	\$294.62	\$112.83	\$260.20	\$112.83	\$236.74
	81	\$178.82	\$304.39	\$269.35	\$304.55	\$116.51	\$269.50	\$116.51	\$245.72
	82	\$181.44	\$314.32	\$278.64	\$314.48	\$120.20	\$278.80	\$120.20	\$254.70
	83	\$182.03	\$334.70	\$298.52	\$334.86	\$127.76	\$298.67	\$127.76	\$274.63
	84	\$182.62	\$355.08	\$318.40	\$355.23	\$135.32	\$318.55	\$135.32	\$294.55
	85+	\$183.21	\$375.46	\$338.28	\$375.61	\$142.88	\$338.43	\$142.88	\$314.48

# Monthly Premium Rates

## Region 7

**OH counties:** Ashland, Columbiana, Coshocton, Guernsey, Harrison, Holmes, Monroe, Muskingum, Noble, Tuscarawas, Washington, Wayne

MALE	AGE	Plan A	Plan C	Plan D	Plan F	Plan FHD	Plan G	Plan GHD	Plan N
	65	\$119.70	\$165.14	\$143.37	\$165.23	\$64.83	\$143.46	\$64.83	\$128.56
	66	\$125.70	\$174.67	\$151.74	\$174.77	\$68.37	\$151.84	\$68.37	\$136.15
	67	\$131.71	\$184.20	\$160.11	\$184.31	\$71.91	\$160.21	\$71.91	\$143.74
	68	\$137.71	\$193.73	\$168.48	\$193.85	\$75.45	\$168.59	\$75.45	\$151.33
	69	\$143.72	\$203.27	\$176.85	\$203.38	\$78.99	\$176.96	\$78.99	\$158.93
	70	\$149.72	\$212.80	\$185.21	\$212.92	\$82.53	\$185.33	\$82.53	\$166.52
	71	\$155.72	\$222.33	\$193.58	\$222.46	\$86.07	\$193.71	\$86.07	\$174.11
	72	\$161.73	\$231.86	\$201.95	\$232.00	\$89.61	\$202.08	\$89.61	\$181.70
	73	\$167.30	\$242.38	\$211.35	\$242.52	\$93.51	\$211.48	\$93.51	\$190.39
	74	\$172.87	\$252.90	\$220.75	\$253.04	\$97.41	\$220.88	\$97.41	\$199.07
	75	\$178.44	\$263.42	\$230.15	\$263.56	\$101.32	\$230.28	\$101.32	\$207.75
	76	\$184.01	\$273.93	\$239.54	\$274.09	\$105.22	\$239.69	\$105.22	\$216.43
	77	\$189.58	\$284.45	\$248.94	\$284.61	\$109.13	\$249.09	\$109.13	\$225.11
	78	\$193.33	\$294.92	\$258.57	\$295.07	\$113.01	\$258.72	\$113.01	\$234.26
	79	\$197.08	\$305.38	\$268.20	\$305.54	\$116.89	\$268.35	\$116.89	\$243.41
	80	\$200.83	\$315.85	\$277.83	\$316.01	\$120.78	\$277.98	\$120.78	\$252.57
	81	\$204.59	\$326.31	\$287.45	\$326.48	\$124.66	\$287.61	\$124.66	\$261.72
	82	\$208.34	\$336.78	\$297.08	\$336.94	\$128.54	\$297.24	\$128.54	\$270.87
	83	\$210.96	\$357.05	\$316.46	\$357.22	\$136.07	\$316.62	\$136.07	\$289.94
	84	\$213.58	\$377.33	\$335.84	\$377.49	\$143.59	\$336.00	\$143.59	\$309.02
	85+	\$216.20	\$397.60	\$355.22	\$397.77	\$151.11	\$355.38	\$151.11	\$328.09

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After the first one month's payments, the term of this coverage is for one month if you have chosen monthly premium payments. If you prepay this coverage on a quarterly, semi-annual or annual basis, the term of the coverage will be the period prepaid. The policy renews automatically, subject to the right of THP Insurance Company to change premium charges.

FEMALE	AGE	Plan A	Plan C	Plan D	Plan F	Plan FHD	Plan G	Plan GHD	Plan N
	65	\$126.94	\$170.45	\$147.43	\$170.56	\$66.81	\$147.53	\$66.81	\$131.67
	66	\$131.10	\$177.97	\$154.13	\$178.08	\$69.60	\$154.23	\$69.60	\$137.83
	67	\$135.25	\$185.49	\$160.82	\$185.60	\$72.39	\$160.92	\$72.39	\$143.98
	68	\$139.41	\$193.01	\$167.51	\$193.12	\$75.18	\$167.62	\$75.18	\$150.14
	69	\$143.57	\$200.53	\$174.20	\$200.65	\$77.97	\$174.31	\$77.97	\$156.29
	70	\$147.72	\$208.05	\$180.89	\$208.17	\$80.76	\$181.01	\$80.76	\$162.45
	71	\$151.88	\$215.57	\$187.58	\$215.69	\$83.56	\$187.70	\$83.56	\$168.60
	72	\$156.04	\$223.09	\$194.27	\$223.21	\$86.35	\$194.39	\$86.35	\$174.76
	73	\$159.50	\$231.33	\$201.78	\$231.46	\$89.41	\$201.90	\$89.41	\$181.83
	74	\$162.95	\$239.58	\$209.29	\$239.71	\$92.47	\$209.42	\$92.47	\$188.89
	75	\$166.41	\$247.82	\$216.80	\$247.96	\$95.53	\$216.93	\$95.53	\$195.96
	76	\$169.86	\$256.07	\$224.31	\$256.21	\$98.59	\$224.44	\$98.59	\$203.03
	77	\$173.32	\$264.31	\$231.82	\$264.45	\$101.65	\$231.95	\$101.65	\$210.10
	78	\$175.76	\$273.53	\$240.43	\$273.67	\$105.07	\$240.57	\$105.07	\$218.41
	79	\$178.21	\$282.75	\$249.05	\$282.90	\$108.49	\$249.19	\$108.49	\$226.72
	80	\$180.65	\$291.97	\$257.67	\$292.12	\$111.91	\$257.80	\$111.91	\$235.03
	81	\$183.09	\$301.19	\$266.28	\$301.34	\$115.33	\$266.42	\$115.33	\$243.35
	82	\$185.54	\$310.41	\$274.90	\$310.56	\$118.75	\$275.04	\$118.75	\$251.66
	83	\$185.29	\$328.40	\$292.50	\$328.55	\$125.43	\$292.64	\$125.43	\$269.33
	84	\$185.04	\$346.40	\$310.10	\$346.54	\$132.11	\$310.23	\$132.11	\$287.00
	85+	\$184.79	\$364.39	\$327.70	\$364.53	\$138.78	\$327.83	\$138.78	\$304.67

# Monthly Premium Rates

## Region 8

**WV counties:** Barbour, Berkeley, Braxton, Cabell, Calhoun, Doddridge, Fayette, Gilmer, Grant, Greenbrier, Hardy, Harrison, Jackson, Jefferson, Lewis, Lincoln, Logan, Mason, Marion, McDowell, Mercer, Mineral, Mingo, Monroe, Morgan, Nicholas, Pendleton, Pleasants, Pocahontas, Putnam, Raleigh, Randolph, Ritchie, Roane, Summers, Taylor, Tucker, Tyler, Upshur, Wayne, Webster, Wetzel, Wirt, Wood, Wyoming

MALE	AGE	Plan A	Plan C	Plan D	Plan F	Plan FHD	Plan G	Plan GHD	Plan N
	65	\$113.23	\$156.66	\$135.26	\$156.85	\$61.74	\$135.45	\$61.74	\$121.02
	66	\$118.90	\$165.67	\$143.13	\$165.87	\$65.09	\$143.32	\$65.09	\$128.15
	67	\$124.57	\$174.68	\$151.00	\$174.89	\$68.44	\$151.20	\$68.44	\$135.27
	68	\$130.24	\$183.69	\$158.87	\$183.91	\$71.78	\$159.08	\$71.78	\$142.39
	69	\$135.91	\$192.70	\$166.74	\$192.93	\$75.13	\$166.95	\$75.13	\$149.51
	70	\$141.58	\$201.71	\$174.60	\$201.95	\$78.48	\$174.83	\$78.48	\$156.63
	71	\$147.25	\$210.72	\$182.47	\$210.97	\$81.82	\$182.71	\$81.82	\$163.76
	72	\$152.92	\$219.73	\$190.34	\$219.98	\$85.17	\$190.59	\$85.17	\$170.88
	73	\$158.19	\$229.65	\$199.17	\$229.92	\$88.85	\$199.43	\$88.85	\$179.02
	74	\$163.46	\$239.58	\$208.00	\$239.85	\$92.54	\$208.26	\$92.54	\$187.17
	75	\$168.74	\$249.50	\$216.83	\$249.79	\$96.23	\$217.10	\$96.23	\$195.31
	76	\$174.01	\$259.43	\$225.66	\$259.72	\$99.91	\$225.94	\$99.91	\$203.45
	77	\$179.28	\$269.35	\$234.49	\$269.66	\$103.60	\$234.78	\$103.60	\$211.59
	78	\$182.85	\$279.20	\$243.53	\$279.51	\$107.26	\$243.83	\$107.26	\$220.18
	79	\$186.43	\$289.05	\$252.57	\$289.37	\$110.91	\$252.87	\$110.91	\$228.77
	80	\$190.00	\$298.90	\$261.62	\$299.22	\$114.57	\$261.92	\$114.57	\$237.35
	81	\$193.58	\$308.75	\$270.66	\$309.08	\$118.22	\$270.96	\$118.22	\$245.94
	82	\$197.15	\$318.60	\$279.70	\$318.93	\$121.88	\$280.01	\$121.88	\$254.52
	83	\$199.74	\$337.62	\$297.87	\$337.95	\$128.94	\$298.18	\$128.94	\$272.41
	84	\$202.33	\$356.64	\$316.05	\$356.97	\$136.00	\$316.36	\$136.00	\$290.30
	85+	\$204.92	\$375.66	\$334.22	\$375.99	\$143.05	\$334.54	\$143.05	\$308.19





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After the first one month's payments, the term of this coverage is for one month if you have chosen monthly premium payments. If you prepay this coverage on a quarterly, semi-annual or annual basis, the term of the coverage will be the period prepaid. The policy renews automatically, subject to the right of THP Insurance Company to change premium charges.

FEMALE	AGE	Plan A	Plan C	Plan D	Plan F	Plan FHD	Plan G	Plan GHD	Plan N
	65	\$120.03	\$161.74	\$139.10	\$161.94	\$63.63	\$139.29	\$63.63	\$123.95
	66	\$123.96	\$168.84	\$145.39	\$169.05	\$66.27	\$145.59	\$66.27	\$129.72
	67	\$127.89	\$175.94	\$151.68	\$176.15	\$68.91	\$151.88	\$68.91	\$135.49
	68	\$131.82	\$183.04	\$157.96	\$183.26	\$71.54	\$158.18	\$71.54	\$141.27
	69	\$135.75	\$190.13	\$164.25	\$190.36	\$74.18	\$164.47	\$74.18	\$147.04
	70	\$139.69	\$197.23	\$170.54	\$197.47	\$76.81	\$170.77	\$76.81	\$152.82
	71	\$143.62	\$204.33	\$176.83	\$204.57	\$79.45	\$177.06	\$79.45	\$158.59
	72	\$147.55	\$211.43	\$183.12	\$211.68	\$82.09	\$183.36	\$82.09	\$164.36
	73	\$150.83	\$219.20	\$190.17	\$219.45	\$84.97	\$190.41	\$84.97	\$170.99
	74	\$154.12	\$226.97	\$197.22	\$227.22	\$87.85	\$197.47	\$87.85	\$177.62
	75	\$157.40	\$234.73	\$204.27	\$235.00	\$90.74	\$204.53	\$90.74	\$184.25
	76	\$160.68	\$242.50	\$211.33	\$242.77	\$93.62	\$211.58	\$93.62	\$190.88
	77	\$163.97	\$250.27	\$218.38	\$250.54	\$96.51	\$218.64	\$96.51	\$197.51
	78	\$166.31	\$258.94	\$226.47	\$259.21	\$99.72	\$226.73	\$99.72	\$205.31
	79	\$168.66	\$267.60	\$234.55	\$267.88	\$102.94	\$234.82	\$102.94	\$213.11
	80	\$171.00	\$276.27	\$242.64	\$276.55	\$106.16	\$242.91	\$106.16	\$220.90
	81	\$173.34	\$284.93	\$250.73	\$285.22	\$109.37	\$251.00	\$109.37	\$228.70
	82	\$175.69	\$293.60	\$258.82	\$293.89	\$112.59	\$259.09	\$112.59	\$236.50
	83	\$175.58	\$310.44	\$275.31	\$310.72	\$118.84	\$275.58	\$118.84	\$253.07
	84	\$175.47	\$327.29	\$291.81	\$327.56	\$125.08	\$292.08	\$125.08	\$269.64
	85+	\$175.36	\$344.13	\$308.31	\$344.40	\$131.33	\$308.57	\$131.33	\$286.21

# Monthly Premium Rates

## Region 9

**OH counties:** Adams, Allen, Ashtabula, Athens, Auglaize, Brown, Butler, Champaign, Clark, Clermont, Clinton, Crawford, Cuyahoga, Darke, Defiance, Delaware, Erie, Fairfield, Fayette, Franklin, Fulton, Gallia, Geauga, Greene, Hamilton, Hancock, Hardin, Henry, Highland, Hocking, Huron, Jackson, Knox, Lake, Lawrence, Licking, Logan, Lorain, Lucas, Madison, Marion, Meigs, Mercer, Miami, Montgomery, Morgan, Morrow, Ottawa, Paulding, Perry, Pickaway, Pike, Preble, Putnam, Richland, Ross, Sandusky, Scioto, Seneca, Shelby, Union, Van Wert, Vinton, Warren, Williams, Wood, Wyandot

MALE	AGE	Plan A	Plan C	Plan D	Plan F	Plan FHD	Plan G	Plan GHD	Plan N
	65	\$117.58	\$163.46	\$141.77	\$163.56	\$64.20	\$141.87	\$64.20	\$126.89
	66	\$123.54	\$173.00	\$150.14	\$173.10	\$67.74	\$150.24	\$67.74	\$134.48
	67	\$129.50	\$182.53	\$158.51	\$182.65	\$71.28	\$158.62	\$71.28	\$142.07
	68	\$135.46	\$192.07	\$166.89	\$192.19	\$74.82	\$167.00	\$74.82	\$149.67
	69	\$141.42	\$201.61	\$175.26	\$201.73	\$78.36	\$175.38	\$78.36	\$157.26
	70	\$147.38	\$211.14	\$183.63	\$211.27	\$81.90	\$183.75	\$81.90	\$164.85
	71	\$153.35	\$220.68	\$192.00	\$220.81	\$85.44	\$192.13	\$85.44	\$172.44
	72	\$159.31	\$230.22	\$200.38	\$230.36	\$88.98	\$200.51	\$88.98	\$180.03
	73	\$164.94	\$240.87	\$209.91	\$241.02	\$92.94	\$210.04	\$92.94	\$188.84
	74	\$170.57	\$251.53	\$219.44	\$251.67	\$96.89	\$219.58	\$96.89	\$197.65
	75	\$176.20	\$262.18	\$228.97	\$262.33	\$100.85	\$229.11	\$100.85	\$206.45
	76	\$181.83	\$272.84	\$238.49	\$272.99	\$104.80	\$238.64	\$104.80	\$215.26
	77	\$187.46	\$283.49	\$248.02	\$283.65	\$108.76	\$248.18	\$108.76	\$224.07
	78	\$191.46	\$294.32	\$258.00	\$294.48	\$112.78	\$258.15	\$112.78	\$233.56
	79	\$195.46	\$305.15	\$267.97	\$305.31	\$116.80	\$268.13	\$116.80	\$243.05
	80	\$199.46	\$315.97	\$277.95	\$316.14	\$120.81	\$278.11	\$120.81	\$252.54
	81	\$203.46	\$326.80	\$287.92	\$326.97	\$124.83	\$288.09	\$124.83	\$262.03
	82	\$207.46	\$337.63	\$297.90	\$337.80	\$128.85	\$298.06	\$128.85	\$271.53
	83	\$211.04	\$359.19	\$318.51	\$359.37	\$136.85	\$318.67	\$136.85	\$291.81
	84	\$214.62	\$380.75	\$339.12	\$380.93	\$144.85	\$339.28	\$144.85	\$312.10
	85+	\$218.20	\$402.32	\$359.73	\$402.49	\$152.85	\$359.89	\$152.85	\$332.38



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## FEMALE

AGE	Plan A	Plan C	Plan D	Plan F	Plan FHD	Plan G	Plan GHD	Plan N
65	\$124.39	\$168.29	\$145.37	\$168.40	\$65.99	\$145.47	\$65.99	\$129.54
66	\$128.57	\$175.89	\$152.13	\$176.00	\$68.81	\$152.24	\$68.81	\$135.76
67	\$132.76	\$183.48	\$158.89	\$183.60	\$71.63	\$159.00	\$71.63	\$141.99
68	\$136.94	\$191.08	\$165.66	\$191.19	\$74.45	\$165.77	\$74.45	\$148.21
69	\$141.12	\$198.67	\$172.42	\$198.79	\$77.27	\$172.54	\$77.27	\$154.44
70	\$145.31	\$206.27	\$179.18	\$206.39	\$80.09	\$179.30	\$80.09	\$160.66
71	\$149.49	\$213.86	\$185.95	\$213.99	\$82.91	\$186.07	\$82.91	\$166.88
72	\$153.67	\$221.46	\$192.71	\$221.59	\$85.73	\$192.84	\$85.73	\$173.11
73	\$157.27	\$229.92	\$200.43	\$230.06	\$88.87	\$200.56	\$88.87	\$180.38
74	\$160.87	\$238.39	\$208.16	\$238.53	\$92.02	\$208.29	\$92.02	\$187.66
75	\$164.47	\$246.86	\$215.88	\$247.00	\$95.16	\$216.01	\$95.16	\$194.93
76	\$168.07	\$255.33	\$223.60	\$255.47	\$98.30	\$223.74	\$98.30	\$202.21
77	\$171.67	\$263.80	\$231.32	\$263.94	\$101.45	\$231.46	\$101.45	\$209.48
78	\$174.42	\$273.44	\$240.35	\$273.59	\$105.03	\$240.49	\$105.03	\$218.20
79	\$177.17	\$283.09	\$249.37	\$283.24	\$108.61	\$249.52	\$108.61	\$226.91
80	\$179.92	\$292.74	\$258.40	\$292.89	\$112.19	\$258.54	\$112.19	\$235.63
81	\$182.67	\$302.39	\$267.43	\$302.54	\$115.77	\$267.57	\$115.77	\$244.34
82	\$185.42	\$312.03	\$276.45	\$312.19	\$119.35	\$276.60	\$119.35	\$253.06
83	\$186.28	\$331.50	\$295.46	\$331.65	\$126.57	\$295.60	\$126.57	\$272.11
84	\$187.15	\$350.96	\$314.46	\$351.10	\$133.79	\$314.60	\$133.79	\$291.17
85+	\$188.02	\$370.42	\$333.46	\$370.56	\$141.01	\$333.60	\$141.01	\$310.22

# Monthly Premium Rates

## Region 10

WV counties: Boone, Clay, Kanawha

MALE	AGE	Plan A	Plan C	Plan D	Plan F	Plan FHD	Plan G	Plan GHD	Plan N
	65	\$107.64	\$148.92	\$128.58	\$149.10	\$58.69	\$128.75	\$58.69	\$115.04
	66	\$113.03	\$157.48	\$136.06	\$157.67	\$61.87	\$136.24	\$61.87	\$121.81
	67	\$118.42	\$166.05	\$143.54	\$166.24	\$65.05	\$143.73	\$65.05	\$128.58
	68	\$123.80	\$174.61	\$151.01	\$174.82	\$68.23	\$151.21	\$68.23	\$135.35
	69	\$129.19	\$183.17	\$158.49	\$183.39	\$71.42	\$158.70	\$71.42	\$142.12
	70	\$134.58	\$191.74	\$165.97	\$191.96	\$74.60	\$166.19	\$74.60	\$148.89
	71	\$139.97	\$200.30	\$173.45	\$200.54	\$77.78	\$173.68	\$77.78	\$155.66
	72	\$145.36	\$208.87	\$180.93	\$209.11	\$80.96	\$181.17	\$80.96	\$162.43
	73	\$150.37	\$218.30	\$189.32	\$218.55	\$84.46	\$189.57	\$84.46	\$170.17
	74	\$155.38	\$227.73	\$197.72	\$228.00	\$87.97	\$197.97	\$87.97	\$177.91
	75	\$160.39	\$237.17	\$206.11	\$237.44	\$91.47	\$206.37	\$91.47	\$185.65
	76	\$165.41	\$246.60	\$214.51	\$246.88	\$94.97	\$214.77	\$94.97	\$193.39
	77	\$170.42	\$256.04	\$222.90	\$256.33	\$98.48	\$223.18	\$98.48	\$201.14
	78	\$173.81	\$265.40	\$231.50	\$265.69	\$101.95	\$231.77	\$101.95	\$209.30
	79	\$177.21	\$274.77	\$240.09	\$275.06	\$105.43	\$240.37	\$105.43	\$217.46
	80	\$180.61	\$284.13	\$248.68	\$284.43	\$108.90	\$248.97	\$108.90	\$225.62
	81	\$184.01	\$293.49	\$257.28	\$293.80	\$112.38	\$257.57	\$112.38	\$233.78
	82	\$187.41	\$302.86	\$265.87	\$303.17	\$115.86	\$266.17	\$115.86	\$241.94
	83	\$189.87	\$320.93	\$283.15	\$321.24	\$122.56	\$283.44	\$122.56	\$258.94
	84	\$192.33	\$339.01	\$300.42	\$339.32	\$129.27	\$300.72	\$129.27	\$275.95
	85+	\$194.79	\$357.09	\$317.70	\$357.40	\$135.98	\$318.00	\$135.98	\$292.95



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FEMALE	AGE	Plan A	Plan C	Plan D	Plan F	Plan FHD	Plan G	Plan GHD	Plan N
	65	\$114.09	\$153.75	\$132.22	\$153.94	\$60.49	\$132.41	\$60.49	\$117.82
	66	\$117.83	\$160.49	\$138.20	\$160.69	\$62.99	\$138.39	\$62.99	\$123.31
	67	\$121.57	\$167.24	\$144.18	\$167.45	\$65.50	\$144.38	\$65.50	\$128.80
	68	\$125.31	\$173.99	\$150.16	\$174.20	\$68.01	\$150.36	\$68.01	\$134.28
	69	\$129.04	\$180.74	\$156.13	\$180.95	\$70.51	\$156.34	\$70.51	\$139.77
	70	\$132.78	\$187.48	\$162.11	\$187.71	\$73.02	\$162.32	\$73.02	\$145.26
	71	\$136.52	\$194.23	\$168.09	\$194.46	\$75.52	\$168.31	\$75.52	\$150.75
	72	\$140.26	\$200.98	\$174.07	\$201.21	\$78.03	\$174.29	\$78.03	\$156.24
	73	\$143.38	\$208.36	\$180.77	\$208.60	\$80.77	\$181.00	\$80.77	\$162.54
	74	\$146.50	\$215.75	\$187.47	\$215.99	\$83.51	\$187.71	\$83.51	\$168.84
	75	\$149.62	\$223.13	\$194.18	\$223.38	\$86.25	\$194.42	\$86.25	\$175.15
	76	\$152.74	\$230.51	\$200.88	\$230.77	\$89.00	\$201.12	\$89.00	\$181.45
	77	\$155.86	\$237.90	\$207.58	\$238.16	\$91.74	\$207.83	\$91.74	\$187.75
	78	\$158.09	\$246.14	\$215.27	\$246.40	\$94.79	\$215.52	\$94.79	\$195.16
	79	\$160.32	\$254.37	\$222.96	\$254.64	\$97.85	\$223.21	\$97.85	\$202.57
	80	\$162.55	\$262.61	\$230.65	\$262.88	\$100.91	\$230.90	\$100.91	\$209.98
	81	\$164.78	\$270.85	\$238.33	\$271.12	\$103.97	\$238.59	\$103.97	\$217.39
	82	\$167.00	\$279.09	\$246.02	\$279.36	\$107.02	\$246.28	\$107.02	\$224.81
	83	\$166.90	\$295.10	\$261.70	\$295.36	\$112.96	\$261.96	\$112.96	\$240.56
	84	\$166.80	\$311.11	\$277.39	\$311.37	\$118.90	\$277.64	\$118.90	\$256.31
	85+	\$166.70	\$327.12	\$293.07	\$327.38	\$124.84	\$293.31	\$124.84	\$272.07

# Monthly Premium Rates

## Region 11

WV counties: Monongalia, Preston

MALE	AGE	Plan A	Plan C	Plan D	Plan F	Plan FHD	Plan G	Plan GHD	Plan N
	65	\$106.63	\$147.52	\$127.37	\$147.70	\$58.14	\$127.54	\$58.14	\$113.96
	66	\$111.97	\$156.01	\$134.78	\$156.19	\$61.29	\$134.96	\$61.29	\$120.67
	67	\$117.31	\$164.49	\$142.19	\$164.69	\$64.44	\$142.38	\$64.44	\$127.38
	68	\$122.65	\$172.97	\$149.60	\$173.18	\$67.60	\$149.80	\$67.60	\$134.08
	69	\$127.98	\$181.46	\$157.01	\$181.67	\$70.75	\$157.22	\$70.75	\$140.79
	70	\$133.32	\$189.94	\$164.42	\$190.17	\$73.90	\$164.63	\$73.90	\$147.50
	71	\$138.66	\$198.43	\$171.83	\$198.66	\$77.05	\$172.05	\$77.05	\$154.20
	72	\$144.00	\$206.91	\$179.24	\$207.15	\$80.20	\$179.47	\$80.20	\$160.91
	73	\$148.97	\$216.26	\$187.55	\$216.51	\$83.67	\$187.79	\$83.67	\$168.58
	74	\$153.93	\$225.60	\$195.87	\$225.86	\$87.14	\$196.12	\$87.14	\$176.25
	75	\$158.89	\$234.95	\$204.18	\$235.22	\$90.61	\$204.44	\$90.61	\$183.92
	76	\$163.86	\$244.29	\$212.50	\$244.57	\$94.08	\$212.76	\$94.08	\$191.58
	77	\$168.82	\$253.64	\$220.81	\$253.92	\$97.56	\$221.09	\$97.56	\$199.25
	78	\$172.19	\$262.92	\$229.33	\$263.21	\$101.00	\$229.60	\$101.00	\$207.34
	79	\$175.55	\$272.19	\$237.84	\$272.49	\$104.44	\$238.12	\$104.44	\$215.42
	80	\$178.92	\$281.47	\$246.35	\$281.77	\$107.89	\$246.64	\$107.89	\$223.50
	81	\$182.29	\$290.74	\$254.87	\$291.05	\$111.33	\$255.16	\$111.33	\$231.59
	82	\$185.65	\$300.02	\$263.38	\$300.33	\$114.77	\$263.67	\$114.77	\$239.67
	83	\$188.09	\$317.93	\$280.50	\$318.24	\$121.42	\$280.79	\$121.42	\$256.52
	84	\$190.53	\$335.84	\$297.61	\$336.15	\$128.06	\$297.91	\$128.06	\$273.36
	85+	\$192.96	\$353.75	\$314.73	\$354.06	\$134.71	\$315.02	\$134.71	\$290.21



We, THP Insurance Company can only raise your premium if we raise the premium for all policies in this state. Your premium is determined upon your gender and attained age. Your premium will change each year based upon your attained age on the date of your plan renewal, January 1.

After the first one month's payments, the term of this coverage is for one month if you have chosen monthly premium payments. If you prepay this coverage on a quarterly, semi-annual or annual basis, the term of the coverage will be the period prepaid. The policy renews automatically, subject to the right of THP Insurance Company to change premium charges.

## FEMALE

AGE	Plan A	Plan C	Plan D	Plan F	Plan FHD	Plan G	Plan GHD	Plan N
65	\$113.02	\$152.31	\$130.99	\$152.50	\$59.92	\$131.17	\$59.92	\$116.72
66	\$116.73	\$158.99	\$136.91	\$159.19	\$62.40	\$137.10	\$62.40	\$122.15
67	\$120.43	\$165.67	\$142.83	\$165.88	\$64.89	\$143.02	\$64.89	\$127.59
68	\$124.13	\$172.36	\$148.75	\$172.57	\$67.37	\$148.95	\$67.37	\$133.03
69	\$127.84	\$179.04	\$154.67	\$179.26	\$69.85	\$154.88	\$69.85	\$138.46
70	\$131.54	\$185.73	\$160.59	\$185.95	\$72.33	\$160.80	\$72.33	\$143.90
71	\$135.24	\$192.41	\$166.51	\$192.64	\$74.82	\$166.73	\$74.82	\$149.34
72	\$138.94	\$199.09	\$172.44	\$199.33	\$77.30	\$172.66	\$77.30	\$154.78
73	\$142.04	\$206.41	\$179.08	\$206.65	\$80.01	\$179.30	\$80.01	\$161.02
74	\$145.13	\$213.73	\$185.72	\$213.97	\$82.73	\$185.95	\$82.73	\$167.26
75	\$148.22	\$221.04	\$192.36	\$221.29	\$85.45	\$192.60	\$85.45	\$173.50
76	\$151.31	\$228.36	\$199.00	\$228.61	\$88.16	\$199.24	\$88.16	\$179.75
77	\$154.40	\$235.67	\$205.64	\$235.93	\$90.88	\$205.89	\$90.88	\$185.99
78	\$156.61	\$243.83	\$213.26	\$244.09	\$93.91	\$213.50	\$93.91	\$193.33
79	\$158.82	\$251.99	\$220.87	\$252.25	\$96.94	\$221.12	\$96.94	\$200.67
80	\$161.02	\$260.15	\$228.49	\$260.42	\$99.96	\$228.74	\$99.96	\$208.02
81	\$163.23	\$268.31	\$236.10	\$268.58	\$102.99	\$236.36	\$102.99	\$215.36
82	\$165.44	\$276.47	\$243.72	\$276.74	\$106.02	\$243.98	\$106.02	\$222.70
83	\$165.34	\$292.33	\$259.25	\$292.60	\$111.90	\$259.51	\$111.90	\$238.31
84	\$165.24	\$308.19	\$274.79	\$308.45	\$117.79	\$275.04	\$117.79	\$253.91
85+	\$165.13	\$324.06	\$290.32	\$324.31	\$123.67	\$290.57	\$123.67	\$269.52

# Monthly Premium Rates

## Region 12

WV counties: Hampshire

MALE	AGE	Plan A	Plan C	Plan D	Plan F	Plan FHD	Plan G	Plan GHD	Plan N
	65	\$94.47	\$130.71	\$112.85	\$130.86	\$51.51	\$113.00	\$51.51	\$100.97
	66	\$99.20	\$138.22	\$119.42	\$138.39	\$54.31	\$119.58	\$54.31	\$106.91
	67	\$103.93	\$145.74	\$125.98	\$145.91	\$57.10	\$126.15	\$57.10	\$112.86
	68	\$108.66	\$153.25	\$132.55	\$153.44	\$59.89	\$132.72	\$59.89	\$118.80
	69	\$113.39	\$160.77	\$139.11	\$160.96	\$62.68	\$139.29	\$62.68	\$124.74
	70	\$118.12	\$168.29	\$145.67	\$168.49	\$65.47	\$145.86	\$65.47	\$130.68
	71	\$122.85	\$175.80	\$152.24	\$176.01	\$68.27	\$152.44	\$68.27	\$136.62
	72	\$127.58	\$183.32	\$158.80	\$183.54	\$71.06	\$159.01	\$71.06	\$142.57
	73	\$131.98	\$191.60	\$166.17	\$191.82	\$74.13	\$166.38	\$74.13	\$149.36
	74	\$136.38	\$199.88	\$173.54	\$200.11	\$77.21	\$173.76	\$77.21	\$156.15
	75	\$140.78	\$208.16	\$180.91	\$208.40	\$80.28	\$181.13	\$80.28	\$162.95
	76	\$145.18	\$216.44	\$188.27	\$216.69	\$83.36	\$188.51	\$83.36	\$169.74
	77	\$149.57	\$224.73	\$195.64	\$224.98	\$86.43	\$195.88	\$86.43	\$176.54
	78	\$152.56	\$232.94	\$203.18	\$233.20	\$89.48	\$203.43	\$89.48	\$183.70
	79	\$155.54	\$241.16	\$210.73	\$241.42	\$92.54	\$210.97	\$92.54	\$190.86
	80	\$158.52	\$249.38	\$218.27	\$249.64	\$95.59	\$218.52	\$95.59	\$198.02
	81	\$161.50	\$257.60	\$225.81	\$257.87	\$98.64	\$226.07	\$98.64	\$205.19
	82	\$164.49	\$265.82	\$233.35	\$266.09	\$101.69	\$233.61	\$101.69	\$212.35
	83	\$166.65	\$281.68	\$248.52	\$281.96	\$107.58	\$248.78	\$107.58	\$227.28
	84	\$168.81	\$297.55	\$263.68	\$297.82	\$113.46	\$263.94	\$113.46	\$242.20
	85+	\$170.96	\$313.42	\$278.85	\$313.69	\$119.35	\$279.11	\$119.35	\$257.13



We, THP Insurance Company can only raise your premium if we raise the premium for all policies in this state. Your premium is determined upon your gender and attained age. Your premium will change each year based upon your attained age on the date of your plan renewal, January 1.

After the first one month's payments, the term of this coverage is for one month if you have chosen monthly premium payments. If you prepay this coverage on a quarterly, semi-annual or annual basis, the term of the coverage will be the period prepaid. The policy renews automatically, subject to the right of THP Insurance Company to change premium charges.

FEMALE	AGE	Plan A	Plan C	Plan D	Plan F	Plan FHD	Plan G	Plan GHD	Plan N
	65	\$100.14	\$134.94	\$116.05	\$135.11	\$53.09	\$116.22	\$53.09	\$103.41
	66	\$103.42	\$140.87	\$121.30	\$141.04	\$55.29	\$121.47	\$55.29	\$108.23
	67	\$106.70	\$146.79	\$126.55	\$146.97	\$57.49	\$126.72	\$57.49	\$113.04
	68	\$109.98	\$152.71	\$131.79	\$152.90	\$59.69	\$131.97	\$59.69	\$117.86
	69	\$113.26	\$158.63	\$137.04	\$158.82	\$61.89	\$137.22	\$61.89	\$122.68
	70	\$116.54	\$164.55	\$142.28	\$164.75	\$64.09	\$142.47	\$64.09	\$127.50
	71	\$119.82	\$170.48	\$147.53	\$170.68	\$66.29	\$147.72	\$66.29	\$132.31
	72	\$123.10	\$176.40	\$152.78	\$176.61	\$68.49	\$152.98	\$68.49	\$137.13
	73	\$125.84	\$182.88	\$158.66	\$183.09	\$70.89	\$158.86	\$70.89	\$142.66
	74	\$128.58	\$189.36	\$164.54	\$189.58	\$73.30	\$164.75	\$73.30	\$148.19
	75	\$131.32	\$195.84	\$170.43	\$196.06	\$75.70	\$170.64	\$75.70	\$153.72
	76	\$134.06	\$202.32	\$176.31	\$202.55	\$78.11	\$176.53	\$78.11	\$159.26
	77	\$136.80	\$208.80	\$182.20	\$209.03	\$80.52	\$182.41	\$80.52	\$164.79
	78	\$138.76	\$216.03	\$188.94	\$216.26	\$83.20	\$189.16	\$83.20	\$171.29
	79	\$140.71	\$223.26	\$195.69	\$223.50	\$85.88	\$195.91	\$85.88	\$177.80
	80	\$142.67	\$230.49	\$202.44	\$230.73	\$88.57	\$202.66	\$88.57	\$184.30
	81	\$144.62	\$237.72	\$209.19	\$237.96	\$91.25	\$209.41	\$91.25	\$190.81
	82	\$146.58	\$244.95	\$215.93	\$245.19	\$93.93	\$216.16	\$93.93	\$197.31
	83	\$146.49	\$259.01	\$229.70	\$259.24	\$99.15	\$229.92	\$99.15	\$211.14
	84	\$146.40	\$273.06	\$243.46	\$273.29	\$104.36	\$243.68	\$104.36	\$224.97
	85+	\$146.31	\$287.11	\$257.23	\$287.34	\$109.57	\$257.44	\$109.57	\$238.79

# Outline of



# Medicare Supplement Plan Coverage

## Premium Information

We, THP Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this state.

## Disclosures

Use this outline to compare benefits and premiums among policies.

## 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 health insurance company.

## Right to Return Policy

If you find that you are not satisfied with your policy, you may return it to:

**The Health Plan**  
**1110 Main Street**  
**Wheeling, WV 26003**

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 THP 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 "Medicare & You" 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 your application carefully before you sign it. Be certain that all information has been properly recorded.

# Benefit Chart of Medicare Supplement Plans

Sold on or after January 1, 2020

This chart shows the benefits 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.

Medicare first  
eligible before  
2020 only

## PLANS AVAILABLE TO ALL APPLICANTS

BENEFITS	A	B	D	G <sup>1</sup>	K	L	M	N	C	F <sup>1</sup>
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 <sup>3</sup>	✓	✓
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 2020 <sup>2</sup>					\$5,880 <sup>2</sup>	\$2,940 <sup>2</sup>				

<sup>1</sup> Plans F and G also have a high deductible option which require first paying a plan deductible of \$2,340 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.

<sup>2</sup> 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.

<sup>3</sup> 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.

# 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.

\*\* **NOTICE:** When your Medicare Part A hospital benefits are exhausted, THP Insurance Company 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 on any difference between its billed charges and the amount Medicare would have paid.

Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.

### SERVICES

#### HOSPITALIZATION\*

First 60 days

61-90 days

91 days and after:

- While using 60 lifetime reserve days
- Once lifetime reserve days are used:
  - Additional 365 days
  - Beyond the additional 365 days

#### SKILLED NURSING FACILITY CARE\*

First 20 days

21-100 days

After 101 days

#### BLOOD

First 3 pints

Additional amounts

#### HOSPICE CARE

# Plan A

## MEDICARE PAYS

## PLAN A PAYS

## YOU PAY UNDER PLAN A

Semi-private room and board, general nursing and miscellaneous services and supplies.		
All but \$1,408	\$0	\$1,408 (Part A Deductible)
All but \$352 a day	\$352 a day	\$0
All but \$704 a day	\$704 a day	\$0
\$0	100% of Medicare eligible expenses	\$0**
\$0	\$0	All costs
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.		
All approved amounts	\$0	\$0
All but \$176 a day	\$0	Up to \$176 a day
\$0	\$0	All costs
\$0	3 pints	\$0
100%	\$0	\$0
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

# Medicare (Part B)

## Medical Services Per Calendar Year

\* Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

### SERVICES

#### MEDICAL EXPENSES

First \$198 of Medicare-Approved Amounts\*

Remainder of Medicare-Approved Amounts

#### PART B EXCESS CHARGES

#### BLOOD

First 3 pints

Next \$198 of Medicare- Approved Amounts\*

Remainder of Medicare-Approved Amounts

#### CLINICAL LABORATORY SERVICES

Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.

# Plan A

## MEDICARE PAYS

## PLAN A PAYS

## YOU PAY UNDER PLAN A

IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.

\$0

\$0

\$198 (Part B Deductible)

Generally 80%

Generally 20%

\$0

(Above Medicare-Approved Amounts)

\$0

\$0

All costs

\$0

All costs

\$0

\$0

\$0

\$198 (Part B Deductible)

80%

20%

\$0

Tests for Diagnostic Services

100%

\$0

\$0

# Parts A & B

\* Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

## SERVICES

### HOME HEALTH CARE

Medically necessary skilled care services and medical supplies

Durable Medical Equipment:

- First \$198 of Medicare-Approved Amounts\*
- Remainder of Medicare-Approved Amounts

Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.





# Plan A

MEDICARE PAYS	PLAN A PAYS	YOU PAY UNDER PLAN A
(MEDICARE-APPROVED SERVICES)		
100%	\$0	\$0
Generally 80%	\$0	\$198 (Part B Deductible)
80%	20%	\$0

# 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.

\*\* **NOTICE:** When your Medicare Part A hospital benefits are exhausted, THP Insurance Company 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.

Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.

### SERVICES

#### HOSPITALIZATION\*

First 60 days

61-90 days

91 days and after:

- While using 60 lifetime reserve days
- Once lifetime reserve days are used:
  - Additional 365 days
  - Beyond the additional 365 days

#### SKILLED NURSING FACILITY CARE\*

First 20 days

21-100 days

After 101 days

#### BLOOD

First 3 pints

Additional amounts

#### HOSPICE CARE

# Plan C

## MEDICARE PAYS

## PLAN C PAYS

## YOU PAY UNDER PLAN C

Semi-private room and board, general nursing and miscellaneous services and supplies.		
All but \$1,408	\$1,408 (Part A Deductible)	\$0
All but \$352 a day	\$352 a day	\$0
All but \$704 a day	\$704 a day	\$0
\$0	100% of Medicare eligible expenses	\$0**
\$0	\$0	All costs
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.		
All approved amounts	\$0	\$0
All but \$176 a day	Up to \$176 a day	\$0
\$0	\$0	All costs
\$0	3 pints	\$0
100%	\$0	\$0
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

# Medicare (Part B)

## Medical Services Per Calendar Year

\* Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

### SERVICES

#### MEDICAL EXPENSES

First \$198 of Medicare-Approved Amounts\*

Remainder of Medicare-Approved Amounts

#### PART B EXCESS CHARGES

#### BLOOD

First 3 pints

Next \$198 of Medicare-Approved Amounts\*

Remainder of Medicare-Approved Amounts

#### CLINICAL LABORATORY SERVICES

Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.

# Plan C

## MEDICARE PAYS

## PLAN C PAYS

## YOU PAY UNDER PLAN C

IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.

\$0

\$198 (Part B Deductible)

\$0

Generally 80%

Generally 20%

\$0

(Above Medicare-Approved Amounts)

\$0

\$0

All costs

\$0

All costs

\$0

\$0

\$198 (Part B Deductible)

\$0

80%

20%

\$0

Tests for Diagnostic Services

100%

\$0

\$0

# Parts A & B

\* Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

## SERVICES

### HOME HEALTH CARE

Medically necessary skilled care services and medical supplies

Durable Medical Equipment:

- First \$198 of Medicare-Approved Amounts\*
- Remainder of Medicare-Approved Amounts

### FOREIGN TRAVEL NOT COVERED BY MEDICARE

First \$250 each calendar year

Remainder of charges

Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.



# Plan C

## MEDICARE PAYS

## PLAN C PAYS

## YOU PAY UNDER PLAN C

### (MEDICARE-APPROVED SERVICES)

100%	\$0	\$0
\$0	\$198 (Part B Deductible)	\$0
80%	20%	\$0

## OTHER BENEFITS NOT COVERED BY MEDICARE

Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.

\$0	\$0	\$250
\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

# 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.

\*\* **NOTICE:** When your Medicare Part A hospital benefits are exhausted, THP Insurance Company 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.

Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.

### SERVICES

#### HOSPITALIZATION\*

First 60 days

61-90 days

91 days and after:

- While using 60 lifetime reserve days
- Once lifetime reserve days are used:
  - Additional 365 days
  - Beyond the additional 365 days

#### SKILLED NURSING FACILITY CARE\*

First 20 days

21-100 days

After 101 days

#### BLOOD

First 3 pints

Additional amounts

#### HOSPICE CARE



# Plan D

## MEDICARE PAYS

## PLAN D PAYS

## YOU PAY UNDER PLAN D

Semi-private room and board, general nursing and miscellaneous services and supplies.		
All but \$1,408	\$1,408 (Part A Deductible)	\$0
All but \$352 a day	\$352 a day	\$0
All but \$704 a day	\$704 a day	\$0
\$0	100% of Medicare eligible expenses	\$0**
\$0	\$0	All costs
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.		
All approved amounts	\$0	\$0
All but \$176 a day	Up to \$176 a day	\$0
\$0	\$0	All costs
\$0	3 pints	\$0
100%	\$0	\$0
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

# Medicare (Part B)

## Medical Services Per Calendar Year

\* Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

### SERVICES

#### MEDICAL EXPENSES

First \$198 of Medicare-Approved Amounts\*

Remainder of Medicare-Approved Amounts

#### PART B EXCESS CHARGES

#### BLOOD

First 3 pints

Next \$198 of Medicare-Approved Amounts\*

Remainder of Medicare-Approved Amounts

#### CLINICAL LABORATORY SERVICES

Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.

# Plan D

## MEDICARE PAYS

## PLAN D PAYS

## YOU PAY UNDER PLAN D

IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.

\$0

\$0

\$198 (Part B Deductible)

Generally 80%

Generally 20%

\$0

(Above Medicare-Approved Amounts)

\$0

\$0

All costs

\$0

All costs

\$0

\$0

\$0

\$198 (Part B Deductible)

80%

20%

\$0

Tests for Diagnostic Services

100%

\$0

\$0

# Parts A & B

\* Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

## SERVICES

### HOME HEALTH CARE

Medically necessary skilled care services and medical supplies

Durable Medical Equipment:

- First \$198 of Medicare-Approved Amounts\*
- Remainder of Medicare-Approved Amounts

### FOREIGN TRAVEL NOT COVERED BY MEDICARE

First \$250 each calendar year

Remainder of charges

Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.

# Plan D

## MEDICARE PAYS

## PLAN D PAYS

## YOU PAY UNDER PLAN D

### (MEDICARE-APPROVED SERVICES)

100%	\$0	\$0
\$0	\$0	\$198 (Part B Deductible)
80%	20%	\$0

## OTHER BENEFITS NOT COVERED BY MEDICARE

Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.

\$0	\$0	\$250
\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

# 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 F after you have paid a calendar year \$2,340 deductible. Benefits from the high-deductible Plan F will not begin until out-of-pocket expenses are \$2,340. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

\*\*\* NOTICE: When your Medicare Part A hospital benefits are exhausted, THP Insurance Company 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.

**Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.**

### SERVICES

#### HOSPITALIZATION\*

First 60 days

61-90 days

91 days and after:

- While using 60 lifetime reserve days
- Once lifetime reserve days are used:
- Additional 365 days
- Beyond the additional 365 days

#### SKILLED NURSING FACILITY CARE\*

First 20 days

21-100 days

After 101 days

#### BLOOD

First 3 pints

Additional amounts

#### HOSPICE CARE



# Plan F

or High-Deductible Plan F

## MEDICARE PAYS

## AFTER YOU PAY \$2,340 DEDUCTIBLE,\*\* PLAN F PAYS

## IN ADDITION TO \$2,340 DEDUCTIBLE, \*\*YOU PAY UNDER PLAN F

Semi-private room and board, general nursing and miscellaneous services and supplies.		
All but \$1,408	\$1,408 (Part A Deductible)	\$0
All but \$352 a day	\$352 a day	\$0
All but \$704 a day	\$704 a day	\$0
\$0	100% of Medicare eligible expenses	\$0***
\$0	\$0	All costs
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.		
All approved amounts	\$0	\$0
All but \$176 a day	Up to \$176 a day	\$0
\$0	\$0	All costs
\$0	3 pints	\$0
100%	\$0	\$0
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

# Medicare (Part B)

## Medical Services Per Calendar Year

\* Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\* This high deductible plan pays the same benefits as Plan F after you have paid a calendar year \$2,340 deductible. Benefits from the high-deductible Plan F will not begin until out-of-pocket expenses are \$2,340. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

### SERVICES

#### MEDICAL EXPENSES

First \$198 of Medicare-Approved Amounts\*

Remainder of Medicare-Approved Amounts

#### PART B EXCESS CHARGES

#### BLOOD

First 3 pints

Next \$198 of Medicare-Approved Amounts\*

Remainder of Medicare-Approved Amounts

#### CLINICAL LABORATORY SERVICES

Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.





# Plan F

or High-Deductible Plan F

MEDICARE PAYS

AFTER YOU PAY \$2,340 DEDUCTIBLE,\*\* PLAN F PAYS

IN ADDITION TO \$2,340 DEDUCTIBLE, \*\*YOU PAY UNDER PLAN F

IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.

\$0	\$198 (Part B Deductible)	\$0
Generally 80%	Generally 20%	\$0
(Above Medicare-Approved Amounts)		
\$0	100%	\$0
\$0	All costs	\$0
\$0	\$198 (Part B Deductible)	\$0
80%	20%	\$0
Tests for Diagnostic Services		
100%	\$0	\$0

# Parts A & B

- \* Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.
- \*\* This high deductible plan pays the same benefits as Plan F after you have paid a calendar year \$2,340 deductible. Benefits from the high-deductible Plan F will not begin until out-of-pocket expenses are \$2,340. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

## SERVICES

### HOME HEALTH CARE

Medically necessary skilled care services and medical supplies

Durable Medical Equipment:

- First \$198 of Medicare-Approved Amounts\*
- Remainder of Medicare-Approved Amounts

### FOREIGN TRAVEL NOT COVERED BY MEDICARE

First \$250 each calendar year

Remainder of charges

Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.



# Plan F

or High-Deductible Plan F

MEDICARE PAYS

AFTER YOU PAY \$2,340 DEDUCTIBLE,\*\* PLAN F PAYS

IN ADDITION TO \$2,340 DEDUCTIBLE, \*\*YOU PAY UNDER PLAN F

(MEDICARE-APPROVED SERVICES)		
100%	\$0	\$0
\$0	\$198 (Part B Deductible)	\$0
80%	20%	\$0

OTHER BENEFITS NOT COVERED BY MEDICARE

Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.		
\$0	\$0	\$250
\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

# 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 \$2,340 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2,340. 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.

\*\*\* **NOTICE:** When your Medicare Part A hospital benefits are exhausted, THP Insurance Company 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 on any difference between its billed charges and the amount Medicare would have paid.

Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.

### SERVICES

#### HOSPITALIZATION\*

First 60 days

61-90 days

91 days and after:

- While using 60 lifetime reserve days
- Once lifetime reserve days are used:
- Additional 365 days
- Beyond the additional 365 days

#### SKILLED NURSING FACILITY CARE\*

First 20 days

21-100 days

After 101 days

#### BLOOD

First 3 pints

Additional amounts

#### HOSPICE CARE

# Plan G

or High-Deductible Plan G

## MEDICARE PAYS

## AFTER YOU PAY \$2,340 DEDUCTIBLE,\*\* PLAN G PAYS

## IN ADDITION TO \$2,340 DEDUCTIBLE,\*\*YOU PAY UNDER PLAN G

Semi-private room and board, general nursing and miscellaneous services and supplies.		
All but \$1,408	\$1,408 (Part A Deductible)	\$0
All but \$352 a day	\$352 a day	\$0
All but \$704 a day	\$704 a day	\$0
\$0	100% of Medicare eligible expenses	\$0***
\$0	\$0	All costs
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.		
All approved amounts	\$0	\$0
All but \$176 a day	Up to \$176 a day	\$0
\$0	\$0	All costs
\$0	3 pints	\$0
100%	\$0	\$0
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

# Medicare (Part B)

## Medical Services Per Calendar Year

- \* Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an 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 \$2,340 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2,340. 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

#### MEDICAL EXPENSES

First \$198 of Medicare-Approved Amounts\*

Remainder of Medicare-Approved Amounts

#### PART B EXCESS CHARGES

#### BLOOD

First 3 pints

Next \$198 of Medicare-Approved Amounts\*

Remainder of Medicare-Approved Amounts

#### CLINICAL LABORATORY SERVICES

Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.

# Plan G

or High-Deductible Plan G

## MEDICARE PAYS

## AFTER YOU PAY \$2,340 DEDUCTIBLE,\*\* PLAN G PAYS

## IN ADDITION TO \$2,340 DEDUCTIBLE, \*\*YOU PAY UNDER PLAN G

IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.

\$0	\$0	\$198 ( Unless Part B Deductible has been met)
Generally 80%	Generally 20%	\$0
(Above Medicare-Approved Amounts)		
\$0	100%	\$0
\$0	All costs	\$0
\$0	\$0	\$198 ( Unless Part B Deductible has been met)
80%	20%	\$0
Tests for Diagnostic Services		
100%	\$0	\$0

# Parts A & B

- \* Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an 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 \$2,340 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2,340. 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

### HOME HEALTH CARE

Medically necessary skilled care services and medical supplies

Durable Medical Equipment:

- First \$198 of Medicare-Approved Amounts\*
- Remainder of Medicare-Approved Amounts

### FOREIGN TRAVEL NOT COVERED BY MEDICARE

First \$250 each calendar year

Remainder of charges

Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.



# Plan G

or High-Deductible Plan G

## MEDICARE PAYS

## AFTER YOU PAY \$2,340 DEDUCTIBLE\*\* PLAN G PAYS

## IN ADDITION TO \$2,340 DEDUCTIBLE, \*\* YOU PAY UNDER PLAN G

(MEDICARE-APPROVED SERVICES)		
100%	\$0	\$0
\$0	\$0	\$198 ( Unless Part B Deductible has been met)
80%	20%	\$0

## OTHER BENEFITS NOT COVERED BY MEDICARE

Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.		
\$0	\$0	\$250
\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

# 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.
- \*\* NOTICE: When your Medicare Part A hospital benefits are exhausted, THP Insurance Company 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 on any difference between its billed charges and the amount Medicare would have paid.

Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.

### SERVICES

#### HOSPITALIZATION\*

First 60 days

61-90 days

91 days and after:

- While using 60 lifetime reserve days
- Once lifetime reserve days are used:
  - Additional 365 days
  - Beyond the additional 365 days

#### SKILLED NURSING FACILITY CARE\*

First 20 days

21-100 days

After 101 days

#### BLOOD

First 3 pints

Additional amounts

#### HOSPICE CARE

# Plan N

## MEDICARE PAYS

## PLAN N PAYS

## YOU PAY UNDER PLAN N

Semi-private room and board, general nursing and miscellaneous services and supplies.		
All but \$1,408	\$1,408 (Part A Deductible)	\$0
All but \$352 a day	\$352 a day	\$0
All but \$704 a day	\$704 a day	\$0
\$0	100% of Medicare eligible expenses	\$0**
\$0	\$0	All costs
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.		
All approved amounts	\$0	\$0
All but \$176 a day	Up to \$176 a day	\$0
\$0	\$0	All costs
\$0	3 pints	\$0
100%	\$0	\$0
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

# Medicare (Part B)

## Medical Services Per Calendar Year

\* Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.

### SERVICES

#### MEDICAL EXPENSES

First \$198 of Medicare-Approved Amounts\*

Remainder of Medicare-Approved Amounts

#### PART B EXCESS CHARGES

#### BLOOD

First 3 pints

Next \$198 of Medicare-Approved Amounts\*

Remainder of Medicare-Approved Amounts

#### CLINICAL LABORATORY SERVICES

# Plan N

## MEDICARE PAYS

## PLAN N PAYS

## YOU PAY UNDER PLAN N

IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.

\$0	\$0	\$198 (Part B Deductible)
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.
(Above Medicare-Approved Amounts)		
\$0	\$0	All costs
\$0	All costs	\$0
\$0	\$0	\$198 (Part B Deductible)
80%	20%	\$0
Tests for Diagnostic Services		
100%	\$0	\$0

# Parts A & B

\* Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

## SERVICES

### HOME HEALTH CARE

Medically necessary skilled care services and medical supplies

Durable Medical Equipment:

- First \$198 of Medicare-Approved Amounts\*
- Remainder of Medicare-Approved Amounts

### FOREIGN TRAVEL NOT COVERED BY MEDICARE

First \$250 each calendar year

Remainder of charges

Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.



# Plan N

## MEDICARE PAYS

## PLAN N PAYS

## YOU PAY UNDER PLAN N

(Medicare-Approved Services)		
100%	\$0	\$0
\$0	\$0	\$198 (Part B Deductible)
80%	20%	\$0

## OTHER BENEFITS NOT COVERED BY MEDICARE

Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.		
\$0	\$0	\$250
\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum



# THP Insurance Company, Inc. Ben

THP

BENEFIT	MEDICARE PAYS	PLAN A	PLAN C
<b>MEDICARE PART A HOSPITAL CARE</b>			
First 60 days	All but \$1,408 (Part A Deductible)	\$0	\$1,408 (Part A Deductible)
Days 61-90	All but \$352 a day	\$352 a day	\$352 a day
Days 91-150: while using 60 lifetime reserve days	All but \$704 a day	\$704 a day	\$704 a day
Once lifetime reserve days are used: additional 365 days	\$0	100% of Medicare eligible expenses	100% of Medicare eligible expenses
Beyond the additional 365 days	\$0	\$0	\$0
<b>SKILLED NURSING FACILITY CARE</b>			
First 20 days	All approved amounts	\$0	\$0
Days 21 - 100	All but \$176 a day	\$0	Up to \$176 a day
Days 101 and after	\$0	\$0	\$0
<b>BLOOD</b>			
Blood – first 3 pints	\$0	First 3 pints	First 3 pints
Blood – additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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	Medicare copayment/coinsurance

\* The purpose of this communication is a solicitation of insurance from THP Insurance Company, Inc. (THP). THP is a private insurance company not endorsed by or connected with the federal Medicare program or the U.S. government. This communication provides a brief summary of coverage, see your agent or contact THP for specific costs and details of the coverage. Benefits vary by policy.



# Benefits Summary

Choose the Medicare Supplement insurance policy from THP that best meets your needs and budget.\*

## MEDICARE SUPPLEMENT INSURANCE POLICIES PAY

PLAN D	PLAN F**	PLAN G***	PLAN N
\$1,408 (Part A Deductible)	\$1,408 (Part A Deductible)	\$1,408 (Part A Deductible)	\$1,408 (Part A Deductible)
\$352 a day	\$352 a day	\$352 a day	\$352 a day
\$704 a day	\$704 a day	\$704 a day	\$704 a day
100% of Medicare eligible expenses	100% of Medicare eligible expenses	100% of Medicare eligible expenses	100% of Medicare eligible expenses
\$0	\$0	\$0	\$0
\$0	\$0	\$0	\$0
Up to \$176 a day	Up to \$176 a day	Up to \$176 a day	Up to \$176 a day
\$0	\$0	\$0	\$0
First 3 pints	First 3 pints	First 3 pints	First 3 pints
\$0	\$0	\$0	\$0
Medicare copayment/coinsurance	Medicare copayment/coinsurance	Medicare copayment/coinsurance	Medicare copayment/coinsurance

Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.



# THP Insurance Company, Inc. Ben

THP

BENEFIT	MEDICARE PAYS	PLAN A	PLAN C
<b>MEDICARE PART B'S PHYSICIAN SERVICES AND SUPPLIES (PER CALENDAR YEAR)</b>			
Part B deductible \$198	\$0	\$0	\$198 (Part B Deductible)
Coinsurance	Generally 80% (after Part B Deductible)	Generally 20%	Generally 20%
Part B – Excess Charges	\$0	\$0	\$0
Blood – first 3 pints	\$0	First 3 pints	First 3 pints
Blood – next \$198 of Medicare-approved amounts	\$0	\$0	\$198 (Part B Deductible)
Blood – remainder of Medicare-approved amounts	80%	20%	20%
Preventive benefits for Medicare covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare approved amounts	Remainder of Medicare approved amounts
<b>ADDITIONAL BENEFITS</b>			
Foreign Travel – Emergency care outside U.S.	\$0	\$0	80% to a lifetime maximum benefit of \$50,000 (after \$250 annual deductible)

\*\* Plan F also has an option called High Deductible Plan F. This high deductible plan pays the same or offers the same benefits as Plan F after you have paid a calendar year \$2,340 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$2,340. Out-of-pockets expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Parts A and B, but does not include the plan's separate foreign travel emergency deductible.

# Benefits Summary

**Note:** Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high Deductible F.

## MEDICARE SUPPLEMENT INSURANCE POLICIES PAY

PLAN D	PLAN F**	PLAN G***	PLAN N
\$0	\$198 (Part B Deductible)	\$0	\$0
Generally 20%	Generally 20%	Generally 20%	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.
\$0	100%	100%	\$0
First 3 pints	First 3 pints	First 3 pints	First 3 pints
\$0	\$198 (Part B Deductible)	\$0	\$0
20%	20%	20%	20%
Remainder of Medicare approved amounts	Remainder of Medicare approved amounts	Remainder of Medicare approved amounts	Remainder of Medicare approved amounts
80% to a lifetime maximum benefit of \$50,000 (after \$250 annual deductible)	80% to a lifetime maximum benefit of \$50,000 (after \$250 annual deductible)	80% to a lifetime maximum benefit of \$50,000 (after \$250 annual deductible)	80% to a lifetime maximum benefit of \$50,000 (after \$250 annual deductible)

\*\*\* This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2,340 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2,340. 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.



# Guaranteed Issue Guide

Guaranteed issue means your automatic acceptance into specific Medicare Supplement insurance policies without having to complete the “Statement of Health” section of the application.

## HOW TO USE THIS GUIDE

- Review the “Situations” and “Plan Options” in this guide. Pay special attention to the “Time Frame” requirements.
- Turn to the “Guaranteed Issue” section of the application. Circle your applicable “Situation” number. You may skip the “Statement of Health” section of the application.
- Submit required documentation. You must attach proof of the date your previous coverage ended. (Example: A letter from your insurance company giving the dates your coverage began and ended.)

If this Medicare Supplement insurance policy is replacing Medicare Advantage plan coverage, you must request, in writing, to be disenrolled from your Medicare Advantage plan. Your written request will formally confirm that you are disenrolling from your Medicare Advantage plan and replacing it with a Medicare Supplement policy.

If you have any questions about this process, please contact your Medicare Advantage plan.

# 1

## Situation Description

You are 65 years of age or older and are newly enrolled in Medicare Part B.

## Options

If age 65 or older: All plans available from us.

## Time Frame – Open Enrollment Period

You must submit your application no later than six (6) months after the date your Medicare Part B coverage took effect.

# 2

## Situation Description

Upon first becoming eligible for Medicare Part A for benefits at age 65 or older, you enroll in a Medicare Advantage Plan under Medicare Part C, or with a PACE provider under Section 1894 of the Social Security Act, and disenroll from the plan or program by no later than 12 months after the effective date of enrollment.

## Options

If age 65 or older: All plans available from us.

## Time Frame

If your enrollment is involuntarily terminated, your guaranteed issue period begins on the date you receive termination notice and ends 63 days after your coverage is terminated. If your enrollment is voluntarily terminated, your guaranteed issue period begins 60 days before your disenrollment date and ends 63 days after your disenrollment date.

# 3

## Situation Description

You 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 you are enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to you because you disenrolled from the plan.

## Options

If age 65 or older: All plans available from us.

## Time Frame

Your guaranteed issue period begins on the later of the date you receive a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation), or the date that the applicable coverage terminates or ceases, and ends 63 days thereafter.

# 4

## Situation Description

A. You enrolled in one of the following:

- A Medicare Advantage plan; or
- A PACE provider, if you are 65 years of age or older

— **AND** —

B. One of the following occurs:

You involuntarily lost coverage because:

- Your organization lost its certification;
- Your organization stopped providing the plan in your area
- You moved, or a specified change in your circumstance caused you to no longer be eligible for your plan, or the plan terminated for everyone in your residential area. This section does not apply if you lost eligibility because you failed to pay premium or engaged in disruptive behavior.

— **OR** —

You voluntarily terminated coverage but can demonstrate that:

- The organization substantially violated a material provision of its contract with you; or
- The organization or its representative materially misrepresented plan provisions in marketing to you; or
- You meet such other exceptional conditions as the Secretary may provide.

## Options

If age 65 or older: All plans available from us.

## Time Frame

If your enrollment is involuntarily terminated, your guaranteed issue period begins on the date you receive termination notice and ends 63 days after your coverage is terminated.

If your enrollment is voluntarily terminated, your guaranteed issue period begins 60 days before your disenrollment date and ends 63 days after your disenrollment date.

# 5

## Situation Description

A. You enrolled in one of the following:

- An eligible Medicare cost organization;
- A health care prepayment plan; or
- A Medicare SELECT policy

— **AND** —

B. One of the following occurs:

You involuntarily lost coverage because:

- Your organization lost its certification;
- Your organization stopped providing the plan in your area
- You moved, or a specified change in your circumstance caused you to no longer be eligible for your plan, or the plan terminated for everyone in your residential area. This section does not apply if you lost eligibility because you failed to pay premium or engaged in disruptive behavior.

— **OR** —

You voluntarily terminated coverage but can demonstrate that:

- The organization substantially violated a material provision of its contract with you; or
- The organization or its representative materially misrepresented plan provisions in marketing to you; or
- You meet such other exceptional conditions as the Secretary may provide.

## Options

If age 65 or older: All plans available from us.

## Time Frame

If your enrollment is involuntarily terminated, your guaranteed issue period begins on the date you receive termination notice and ends 63 days after your coverage is terminated.

If your enrollment is voluntarily terminated, your guaranteed issue period begins 60 days before your disenrollment date and ends 63 days after your disenrollment date.

# 6

## Situation Description

You enrolled in a Medicare Supplement policy, but your coverage ended description involuntarily because of:

- The issuer's insolvency or the non-issuer organization's bankruptcy;
- OR —
- Another involuntary coverage or enrollment termination.

You enrolled in a Medicare Supplement policy, and you voluntarily terminated your coverage because:

- The insurer substantially violated a material provision of the policy;
- OR —
- The insurer or its representative materially misrepresented a policy provision to you.

## Options

If age 65 or older: All plans available from us.

## Time Frame

Your guaranteed issue period begins on the earlier of the date on which you receive notice of termination, notice of bankruptcy, or a similar notice, or the date on which your coverage was terminated and ends 63 days after coverage terminates.



# 7

## Situation Description

You enrolled in a Medicare Supplement policy. You terminated that Medicare Supplement policy and enrolled, for the first time, in a Medicare Advantage plan, an eligible Medicare risk or cost program, a similar organization under a demonstration project, a Medicare SELECT policy, or a PACE provider, and terminated that enrollment within the first 12 months.

## Options

If age 65 or older where the same Medicare Supplement policy in which you most recently enrolled, if available from the same insurer, or, if not available, all plans available from us.

## Time frame – Open Enrollment Period

If your enrollment is involuntarily terminated, your guaranteed issue period begins on the date you receive termination notice and ends 63 days after your coverage is terminated. If your enrollment is voluntarily terminated, your guaranteed issue period begins 60 days before your disenrollment date and ends 63 days after your disenrollment date. after coverage terminates.

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### Discrimination is Against the Law

The Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact The Health Plan Customer Service Department.

If you believe that The Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: The Health Plan Appeals Coordinator, 1110 Main Street, Wheeling, WV 26003, Phone: 1.877.847.7907, TTY: 711, Fax 740.699.6163, Email: [info@healthplan.org](mailto:info@healthplan.org). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance The Health Plan Customer Service Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1.800.368.1019, 1.800.537.7697 (TDD).

Complaint forms are available at  
<http://www.hhs.gov/ocr/office/file/index.html>.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-847-7907 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-847-7907 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-847-7907 (TTY: 711)

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-847-7907 (ATS: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-847-7907 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-847-7907 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-847-7907 (TTY: 711).번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-847-7907 (телетайп: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-847-7907 (رقم هاتف الصم والبكم: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-847-7907 (TTY: 711) पर कॉल करें।

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-847-7907 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-847-7907 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-847-7907 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-847-7907 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-847-7907 (TTY: 711) まで、お電話にてご連絡ください。

Wann du Deitsch (Pennsylvania German / Dutch) schwetzsch, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-847-7907 (TTY: 711).

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-877-847-7907 (TTY: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-877-847-7907 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-877-847-7907 (телетайп: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-877-847-7907 (TTY: 711).



1110 Main Street  
Wheeling, WV 26003  
**1.877.847.7915 (TTY: 711)**  
[healthplan.org](http://healthplan.org)

**Plan on it.**