Medicare Supplement Plans:
Ohio & West Virginia

The HealthPlan
HEALTHPLAN.ORG

Medicare Supplement Plans

2019

Ohio & West Virginia

FORM # OH: MS16EG
WV: MS16EG

1.877.847.7915

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Introduction

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The HealthPlan
HEALTHPLAN.ORG

Thank you

for requesting information about the Medicare Supplement plans offered by The Health Plan.

You've taken a **great** first step

secure with the plan benefits

supported with the customer care

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 Ohio and West Virginia. We offer Medicare Supplement Plans A, C, D, F, G and N.

May we help you get started? Call 1.877.847.7915 (TTY: call the state relay number 711. When prompted give the Member Services number 1.877.847.7907 and they will connect you to a THP representative.) 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.

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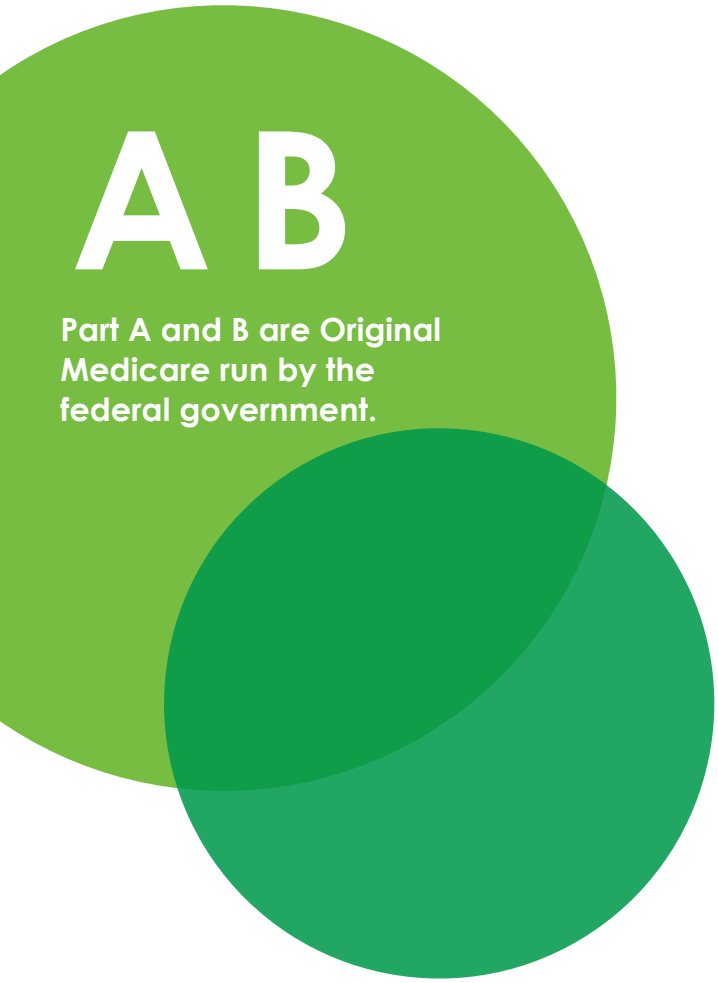

Part A and B are Original Medicare run by the federal government.

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

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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, such as copayments, coinsurance, and yearly deductibles. 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 policies are standardized plans. This means that your core benefits do not change each year. The only difference in a particular plan between insurance companies will usually be the monthly premium that you pay.

- Coverage can only be cancelled for a few select reasons. (i.e., non-payment of your monthly premium, moving outside of the plan's area, etc.) Coverage cannot be cancelled due to your health changing.

Give The Health Plan 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.

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How to **Enroll**

How to enroll

In-Person

We have representatives available to assist you in-person with your enrollment. Please call 1.877.847.7915 (TTY/TDD users, call the state relay number 711. When prompted give the Member Services number 1.877.847.7907 and they will connect you to a THP representative) 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 The Health Plan.

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**

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 **healthplan.org/medicare** to view your online enrollment options with The Health Plan.

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Outline of Medicare Supplement Plan Coverage

Ohio & West Virginia **outline**

THP MEDICARE SUPPLEMENT INSURANCE COVERAGE

	Plan A	Plan B	Plan C	Plan D
Benefit plans A, C, D, F, High Deductible F, G, and N are available (see right)	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 Benefits All plans				
Hospitalization Medicare Part A coinsurance plus coverage for 365 additional days after Medicare benefits end			Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
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		Part A Deductible	Part A Deductible	Part A Deductible
			Part B Deductible	
			Foreign Travel Emergency	Foreign Travel Emergency
Blood First 3 pints of blood each year				
Hospice Part A coinsurance				

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

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

Plan F/F*	Plan G	Plan K	Plan L	Plan M	Plan N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
Part B Excess (100%)	Part B Excess (100%)				
Part B Deductible					
Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
		Out-of Pocket limit $5,560; paid at 100% after limit reached	Out-of Pocket limit $2,780; paid at 100% after limit reached		

*Plan F also offers a high-deductible plan. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,300. 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.

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Premium **Information**

MEDICARE SUPPLEMENT

Monthly Premium Rates Region 1*

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.

MALE

AGE	PLAN A	PLAN C	PLAN D	PLAN F	PLAN FHD	PLAN G	PLAN N
65	$101.52	$145.08	$129.74	$145.17	$59.50	$129.83	$116.63
66	$106.62	$153.57	$137.44	$153.67	$62.78	$137.53	$123.64
67	$111.71	$162.07	$145.13	$162.16	$66.06	$145.23	$130.65
68	$116.81	$170.56	$152.83	$170.66	$69.34	$152.93	$137.65
69	$121.90	$179.05	$160.53	$179.16	$72.61	$160.63	$144.66
70	$126.99	$187.54	$168.23	$187.65	$75.89	$168.34	$151.67
71	$132.09	$196.03	$175.92	$196.15	$79.17	$176.04	$158.68
72	$137.18	$204.52	$183.62	$204.64	$82.45	$183.74	$165.69
73	$141.97	$214.08	$192.46	$214.20	$86.14	$192.59	$173.89
74	$146.75	$223.63	$201.31	$223.76	$89.83	$201.43	$182.09
75	$151.53	$233.19	$210.15	$233.32	$93.52	$210.28	$190.30
76	$156.31	$242.74	$218.99	$242.88	$97.20	$219.13	$198.50
77	$161.10	$252.30	$227.83	$252.44	$100.89	$227.97	$206.70
78	$164.44	$262.12	$237.22	$262.26	$104.68	$237.36	$215.66
79	$167.77	$271.94	$246.61	$272.09	$108.48	$246.76	$224.61
80	$171.11	$281.77	$256.00	$281.91	$112.27	$256.15	$233.57
81	$174.45	$291.59	$265.39	$291.74	$116.06	$265.54	$242.53
82	$177.79	$301.41	$274.78	$301.56	$119.85	$274.93	$251.48
83	$180.56	$321.26	$294.51	$321.41	$127.51	$294.66	$270.91
84	$183.34	$341.11	$314.24	$341.26	$135.17	$314.39	$290.33
85+	$186.11	$360.96	$333.97	$361.11	$142.83	$334.13	$309.75

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.

***Region 1–OH Counties: Portage, Summit**

FEMALE

AGE	PLAN A	PLAN C	PLAN D	PLAN F	PLAN FHD	PLAN G	PLAN N
65	$107.45	$149.13	$132.74	$149.23	$61.07	$132.84	$118.81
66	$111.01	$155.93	$139.01	$156.03	$63.69	$139.10	$124.59
67	$114.57	$162.73	$145.27	$162.83	$66.32	$145.37	$130.38
68	$118.13	$169.53	$151.53	$169.64	$68.94	$151.64	$136.16
69	$121.69	$176.33	$157.80	$176.44	$71.57	$157.90	$141.95
70	$125.25	$183.13	$164.06	$183.24	$74.19	$164.17	$147.74
71	$128.81	$189.93	$170.32	$190.05	$76.82	$170.43	$153.52
72	$132.36	$196.73	$176.59	$196.85	$79.44	$176.70	$159.31
73	$135.39	$204.38	$183.82	$204.50	$82.40	$183.94	$166.14
74	$138.42	$212.04	$191.05	$212.16	$85.35	$191.17	$172.98
75	$141.44	$219.69	$198.29	$219.81	$88.30	$198.41	$179.81
76	$144.47	$227.34	$205.52	$227.46	$91.26	$205.64	$186.65
77	$147.50	$234.99	$212.75	$235.12	$94.21	$212.88	$193.48
78	$149.75	$243.80	$221.31	$243.92	$97.61	$221.44	$201.76
79	$152.01	$252.60	$229.87	$252.73	$101.01	$230.00	$210.03
80	$154.26	$261.41	$238.43	$261.54	$104.40	$238.56	$218.31
81	$156.52	$270.21	$246.98	$270.34	$107.80	$247.12	$226.58
82	$158.78	$279.02	$255.54	$279.15	$111.20	$255.68	$234.86
83	$159.19	$297.09	$273.91	$297.22	$118.17	$274.04	$253.24
84	$159.61	$315.16	$292.27	$315.29	$125.15	$292.40	$271.63
85+	$160.03	$333.23	$310.64	$333.36	$132.12	$310.76	$290.01

MEDICARE SUPPLEMENT

Monthly Premium Rates Region 2*

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.

MALE

AGE	PLAN A	PLAN C	PLAN D	PLAN F	PLAN FHD	PLAN G	PLAN N
65	$101.58	$143.53	$128.20	$143.63	$58.89	$128.29	$114.62
66	$106.64	$151.84	$135.71	$151.94	$62.10	$135.81	$121.42
67	$111.70	$160.14	$143.22	$160.25	$65.31	$143.32	$128.22
68	$116.76	$168.45	$150.73	$168.56	$68.51	$150.84	$135.02
69	$121.81	$176.75	$158.25	$176.87	$71.72	$158.36	$141.82
70	$126.87	$185.06	$165.76	$185.18	$74.93	$165.87	$148.62
71	$131.93	$193.36	$173.27	$193.49	$78.13	$173.39	$155.42
72	$136.99	$201.67	$180.78	$201.80	$81.34	$180.91	$162.22
73	$141.68	$210.90	$189.30	$211.03	$84.90	$189.43	$170.08
74	$146.37	$220.13	$197.81	$220.26	$88.47	$197.95	$177.94
75	$151.07	$229.35	$206.33	$229.49	$92.03	$206.47	$185.80
76	$155.76	$238.58	$214.85	$238.73	$95.59	$214.99	$193.66
77	$160.45	$247.81	$223.36	$247.96	$99.15	$223.51	$201.52
78	$163.61	$257.10	$232.22	$257.25	$102.74	$232.37	$209.94
79	$166.78	$266.39	$241.08	$266.54	$106.32	$241.24	$218.36
80	$169.94	$275.68	$249.94	$275.84	$109.91	$250.10	$226.78
81	$173.10	$284.97	$258.80	$285.13	$113.50	$258.96	$235.21
82	$176.26	$294.26	$267.66	$294.42	$117.08	$267.82	$243.63
83	$178.48	$312.54	$285.84	$312.70	$124.14	$286.00	$261.51
84	$180.69	$330.83	$304.01	$330.99	$131.19	$304.17	$279.40
85+	$182.90	$349.11	$322.18	$349.27	$138.25	$322.34	$297.29

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.

***Region 2– OH Counties: Carroll, Stark**

FEMALE

AGE	PLAN A	PLAN C	PLAN D	PLAN F	PLAN FHD	PLAN G	PLAN N
65	$107.68	$147.93	$131.55	$148.03	$60.59	$131.65	$117.10
66	$111.18	$154.52	$137.60	$154.62	$63.14	$137.70	$122.66
67	$114.68	$161.10	$143.65	$161.21	$65.68	$143.75	$128.22
68	$118.18	$167.69	$149.70	$167.80	$68.22	$149.81	$133.78
69	$121.69	$174.27	$155.75	$174.39	$70.76	$155.86	$139.34
70	$125.19	$180.86	$161.80	$180.98	$73.31	$161.91	$144.90
71	$128.69	$187.45	$167.85	$187.57	$75.85	$167.97	$150.46
72	$132.20	$194.03	$173.90	$194.16	$78.39	$174.02	$156.01
73	$135.11	$201.32	$180.77	$201.45	$81.21	$180.90	$162.48
74	$138.02	$208.61	$187.65	$208.74	$84.02	$187.77	$168.95
75	$140.93	$215.90	$194.52	$216.03	$86.83	$194.65	$175.42
76	$143.84	$223.19	$201.39	$223.32	$89.65	$201.52	$181.89
77	$146.76	$230.48	$208.27	$230.62	$92.46	$208.40	$188.35
78	$148.82	$238.72	$216.26	$238.86	$95.64	$216.39	$196.07
79	$150.88	$246.96	$224.25	$247.09	$98.82	$224.39	$203.78
80	$152.94	$255.19	$232.24	$255.33	$102.00	$232.38	$211.49
81	$155.00	$263.43	$240.24	$263.57	$105.18	$240.38	$219.20
82	$157.06	$271.67	$248.23	$271.81	$108.36	$248.37	$226.91
83	$156.85	$288.05	$264.91	$288.19	$114.68	$265.05	$243.65
84	$156.64	$304.44	$281.60	$304.57	$121.00	$281.73	$260.40
85+	$156.44	$320.82	$298.28	$320.95	$127.32	$298.42	$277.14

MEDICARE SUPPLEMENT

Monthly Premium Rates Region 3*

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.

MALE

AGE	PLAN A	PLAN C	PLAN D	PLAN F	PLAN FHD	PLAN G	PLAN N
65	$110.93	$156.83	$141.43	$156.92	$64.05	$141.52	$127.00
66	$116.50	$166.02	$149.82	$166.11	$67.60	$149.91	$134.63
67	$122.08	$175.20	$158.21	$175.30	$71.14	$158.31	$142.26
68	$127.65	$184.39	$166.59	$184.49	$74.69	$166.70	$149.89
69	$133.23	$193.57	$174.98	$193.68	$78.24	$175.09	$157.52
70	$138.80	$202.76	$183.37	$202.87	$81.78	$183.48	$165.15
71	$144.38	$211.94	$191.76	$212.06	$85.33	$191.88	$172.78
72	$149.95	$221.13	$200.14	$221.25	$88.87	$200.27	$180.41
73	$155.15	$231.43	$209.73	$231.56	$92.85	$209.86	$189.29
74	$160.36	$241.74	$219.32	$241.87	$96.83	$219.46	$198.18
75	$165.56	$252.05	$228.91	$252.18	$100.81	$229.05	$207.06
76	$170.77	$262.35	$238.50	$262.49	$104.79	$238.64	$215.95
77	$175.97	$272.66	$248.09	$272.80	$108.77	$248.24	$224.84
78	$179.54	$283.20	$258.20	$283.35	$112.84	$258.35	$234.47
79	$183.11	$293.75	$268.31	$293.90	$116.91	$268.46	$244.11
80	$186.68	$304.29	$278.42	$304.45	$120.98	$278.57	$253.74
81	$190.25	$314.84	$288.52	$314.99	$125.05	$288.68	$263.38
82	$193.82	$325.38	$298.63	$325.54	$129.12	$298.79	$273.01
83	$196.57	$346.57	$319.69	$346.73	$137.29	$319.85	$293.74
84	$199.32	$367.75	$340.75	$367.91	$145.47	$340.91	$314.47
85+	$202.06	$388.94	$361.81	$389.10	$153.64	$361.97	$335.20

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.

***Region 3– OH Counties: Medina**

FEMALE

AGE	PLAN A	PLAN C	PLAN D	PLAN F	PLAN FHD	PLAN G	PLAN N
65	$117.53	$161.32	$144.87	$161.42	$65.79	$144.97	$129.53
66	$121.41	$168.66	$151.67	$168.76	$68.62	$151.78	$135.80
67	$125.28	$176.00	$158.47	$176.11	$71.45	$158.58	$142.08
68	$129.16	$183.34	$165.27	$183.45	$74.29	$165.38	$148.35
69	$133.04	$190.68	$172.07	$190.79	$77.12	$172.18	$154.63
70	$136.92	$198.02	$178.87	$198.13	$79.95	$178.99	$160.90
71	$140.80	$205.36	$185.67	$205.48	$82.79	$185.79	$167.18
72	$144.67	$212.70	$192.47	$212.82	$85.62	$192.59	$173.45
73	$147.94	$220.92	$200.28	$221.05	$88.79	$200.40	$180.82
74	$151.20	$229.15	$208.08	$229.28	$91.97	$208.21	$188.19
75	$154.46	$237.38	$215.89	$237.51	$95.15	$216.02	$195.56
76	$157.72	$245.61	$223.70	$245.74	$98.32	$223.83	$202.93
77	$160.98	$253.83	$231.50	$253.97	$101.50	$231.64	$210.30
78	$163.36	$263.26	$240.68	$263.40	$105.14	$240.82	$219.17
79	$165.73	$272.69	$249.86	$272.83	$108.78	$250.00	$228.05
80	$168.10	$282.12	$259.04	$282.26	$112.42	$259.18	$236.92
81	$170.47	$291.55	$268.22	$291.69	$116.05	$268.36	$245.79
82	$172.84	$300.98	$277.40	$301.12	$119.69	$277.54	$254.66
83	$172.97	$320.21	$296.91	$320.34	$127.11	$297.05	$274.20
84	$173.09	$339.43	$316.42	$339.56	$134.53	$316.55	$293.74
85+	$173.21	$358.65	$335.93	$358.78	$141.94	$336.06	$313.29

MEDICARE SUPPLEMENT

Monthly Premium Rates Region 4*

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.

MALE

AGE	PLAN A	PLAN C	PLAN D	PLAN F	PLAN FHD	PLAN G	PLAN N
65	$117.40	$164.91	$149.47	$165.02	$67.22	$149.57	$133.48
66	$123.35	$174.60	$158.36	$174.71	$70.96	$158.47	$141.53
67	$129.29	$184.29	$167.25	$184.41	$74.70	$167.37	$149.59
68	$135.23	$193.99	$176.15	$194.11	$78.45	$176.27	$157.64
69	$141.17	$203.68	$185.04	$203.81	$82.19	$185.17	$165.69
70	$147.12	$213.37	$193.93	$213.51	$85.93	$194.06	$173.75
71	$153.06	$223.07	$202.82	$223.21	$89.67	$202.96	$181.80
72	$159.00	$232.76	$211.72	$232.90	$93.41	$211.86	$189.86
73	$164.58	$243.66	$221.90	$243.81	$97.62	$222.05	$199.26
74	$170.16	$254.56	$232.08	$254.72	$101.83	$232.23	$208.66
75	$175.75	$265.46	$242.26	$265.62	$106.04	$242.42	$218.07
76	$181.33	$276.36	$252.44	$276.53	$110.25	$252.61	$227.47
77	$186.91	$287.26	$262.62	$287.43	$114.46	$262.79	$236.87
78	$190.81	$298.46	$273.38	$298.63	$118.78	$273.55	$247.11
79	$194.71	$309.65	$284.14	$309.83	$123.10	$284.31	$257.35
80	$198.61	$320.85	$294.89	$321.03	$127.42	$295.07	$267.58
81	$202.51	$332.05	$305.65	$332.23	$131.74	$305.83	$277.82
82	$206.41	$343.24	$316.41	$343.42	$136.06	$316.59	$288.05
83	$209.67	$365.84	$338.87	$366.02	$144.78	$339.06	$310.17
84	$212.93	$388.44	$361.34	$388.62	$153.50	$361.52	$332.28
85+	$216.19	$411.04	$383.81	$411.22	$162.23	$383.99	$354.40

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.

***Region 4– OH Counties: Jefferson; WV counties: Brooke, Hancock**

FEMALE

AGE	PLAN A	PLAN C	PLAN D	PLAN F	PLAN FHD	PLAN G	PLAN N
65	$124.31	$169.56	$153.07	$169.67	$69.01	$153.18	$136.06
66	$128.46	$177.31	$160.28	$177.43	$72.01	$160.40	$142.70
67	$132.62	$185.07	$167.50	$185.19	$75.00	$167.62	$149.34
68	$136.77	$192.83	$174.72	$192.96	$78.00	$174.84	$155.97
69	$140.92	$200.59	$181.93	$200.72	$80.99	$182.06	$162.61
70	$145.08	$208.35	$189.15	$208.48	$83.99	$189.28	$169.25
71	$149.23	$216.11	$196.37	$216.24	$86.99	$196.50	$175.88
72	$153.38	$223.86	$203.58	$224.00	$89.98	$203.72	$182.52
73	$156.92	$232.59	$211.88	$232.73	$93.35	$212.03	$190.34
74	$160.45	$241.31	$220.19	$241.46	$96.72	$220.33	$198.16
75	$163.98	$250.04	$228.49	$250.18	$100.08	$228.63	$205.98
76	$167.52	$258.76	$236.79	$258.91	$103.45	$236.94	$213.80
77	$171.05	$267.48	$245.09	$267.64	$106.82	$245.24	$221.62
78	$173.69	$277.52	$254.87	$277.67	$110.69	$255.02	$231.06
79	$176.33	$287.55	$264.64	$287.70	$114.56	$264.80	$240.50
80	$178.97	$297.58	$274.42	$297.74	$118.43	$274.58	$249.94
81	$181.61	$307.61	$284.20	$307.77	$122.31	$284.36	$259.38
82	$184.25	$317.64	$293.98	$317.81	$126.18	$294.14	$268.82
83	$184.76	$338.21	$314.82	$338.36	$134.11	$314.98	$289.72
84	$185.27	$358.77	$335.66	$358.92	$142.04	$335.82	$310.61
85+	$185.78	$379.33	$356.51	$379.48	$149.98	$356.66	$331.50

MEDICARE SUPPLEMENT

Monthly Premium Rates Region 5*

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.

MALE

AGE	PLAN A	PLAN C	PLAN D	PLAN F	PLAN FHD	PLAN G	PLAN N
65	$105.23	$147.13	$131.78	$147.22	$60.34	$131.86	$117.97
66	$110.49	$155.62	$139.47	$155.71	$63.62	$139.56	$124.95
67	$115.75	$164.11	$147.17	$164.21	$66.90	$147.26	$131.92
68	$121.01	$172.60	$154.86	$172.70	$70.17	$154.96	$138.89
69	$126.27	$181.09	$162.56	$181.20	$73.45	$162.66	$145.86
70	$131.53	$189.58	$170.25	$189.69	$76.73	$170.36	$152.84
71	$136.79	$198.07	$177.95	$198.18	$80.01	$178.07	$159.81
72	$142.05	$206.56	$185.64	$206.68	$83.28	$185.77	$166.78
73	$146.95	$215.96	$194.33	$216.08	$86.91	$194.46	$174.80
74	$151.84	$225.35	$203.02	$225.48	$90.54	$203.15	$182.82
75	$156.73	$234.75	$211.70	$234.89	$94.17	$211.84	$190.84
76	$161.63	$244.15	$220.39	$244.29	$97.80	$220.53	$198.86
77	$166.52	$253.55	$229.08	$253.69	$101.43	$229.22	$206.88
78	$169.84	$262.96	$238.05	$263.10	$105.06	$238.20	$215.41
79	$173.17	$272.36	$247.03	$272.51	$108.69	$247.17	$223.94
80	$176.49	$281.77	$256.00	$281.92	$112.32	$256.15	$232.47
81	$179.81	$291.17	$264.98	$291.33	$115.95	$265.13	$241.00
82	$183.14	$300.58	$273.95	$300.73	$119.58	$274.11	$249.53
83	$185.56	$318.94	$292.21	$319.10	$126.67	$292.36	$267.49
84	$187.99	$337.31	$310.46	$337.46	$133.75	$310.61	$285.46
85+	$190.42	$355.67	$328.71	$355.83	$140.84	$328.86	$303.42

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.

***Region 5– OH counties: Belmont; WV counties: Marshall, Ohio**

FEMALE

AGE	PLAN A	PLAN C	PLAN D	PLAN F	PLAN FHD	PLAN G	PLAN N
65	$111.52	$151.75	$135.35	$151.84	$62.13	$135.44	$120.66
66	$115.17	$158.46	$141.52	$158.56	$64.72	$141.62	$126.34
67	$118.82	$165.18	$147.70	$165.28	$67.31	$147.80	$132.02
68	$122.47	$171.89	$153.88	$171.99	$69.90	$153.98	$137.70
69	$126.12	$178.60	$160.06	$178.71	$72.49	$160.16	$143.38
70	$129.77	$185.32	$166.23	$185.43	$75.08	$166.34	$149.05
71	$133.42	$192.03	$172.41	$192.15	$77.68	$172.52	$154.73
72	$137.07	$198.74	$178.59	$198.86	$80.27	$178.70	$160.41
73	$140.12	$206.14	$185.57	$206.26	$83.12	$185.69	$166.98
74	$143.17	$213.54	$192.55	$213.66	$85.98	$192.67	$173.55
75	$146.22	$220.93	$199.53	$221.06	$88.83	$199.65	$180.11
76	$149.27	$228.33	$206.50	$228.46	$91.69	$206.63	$186.68
77	$152.32	$235.72	$213.48	$235.85	$94.54	$213.61	$193.25
78	$154.51	$244.04	$221.55	$244.17	$97.75	$221.68	$201.03
79	$156.69	$252.35	$229.62	$252.48	$100.96	$229.75	$208.81
80	$158.87	$260.66	$237.69	$260.79	$104.17	$237.82	$216.60
81	$161.06	$268.97	$245.75	$269.11	$107.38	$245.89	$224.38
82	$163.24	$277.29	$253.82	$277.42	$110.58	$253.95	$232.16
83	$163.17	$293.66	$270.50	$293.80	$116.90	$270.63	$248.90
84	$163.10	$310.04	$287.17	$310.17	$123.22	$287.30	$265.64
85+	$163.03	$326.42	$303.85	$326.55	$129.54	$303.98	$282.38

MEDICARE SUPPLEMENT

Monthly Premium Rates Region 6*

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.

MALE

AGE	PLAN A	PLAN C	PLAN D	PLAN F	PLAN FHD	PLAN G	PLAN N
65	$111.13	$156.95	$141.54	$157.05	$64.11	$141.65	$126.33
66	$116.75	$166.16	$149.96	$166.27	$67.67	$150.07	$133.94
67	$122.36	$175.37	$158.38	$175.49	$71.23	$158.49	$141.56
68	$127.97	$184.59	$166.79	$184.71	$74.78	$166.91	$149.18
69	$133.58	$193.80	$175.21	$193.92	$78.34	$175.33	$156.79
70	$139.20	$203.01	$183.62	$203.14	$81.90	$183.75	$164.41
71	$144.81	$212.23	$192.04	$212.36	$85.46	$192.17	$172.03
72	$150.42	$221.44	$200.45	$221.58	$89.01	$200.59	$179.64
73	$155.70	$231.81	$210.10	$231.95	$93.02	$210.25	$188.55
74	$160.98	$242.17	$219.75	$242.32	$97.02	$219.90	$197.46
75	$166.26	$252.54	$229.40	$252.69	$101.02	$229.55	$206.37
76	$171.54	$262.90	$239.05	$263.06	$105.02	$239.21	$215.28
77	$176.83	$273.27	$248.70	$273.43	$109.02	$248.86	$224.19
78	$180.53	$283.92	$258.92	$284.09	$113.13	$259.08	$233.91
79	$184.23	$294.58	$269.13	$294.74	$117.25	$269.30	$243.63
80	$187.94	$305.23	$279.35	$305.40	$121.36	$279.52	$253.35
81	$191.64	$315.88	$289.57	$316.06	$125.47	$289.74	$263.07
82	$195.35	$326.54	$299.78	$326.71	$129.58	$299.96	$272.79
83	$198.50	$348.06	$321.18	$348.24	$137.89	$321.36	$293.86
84	$201.65	$369.59	$342.58	$369.76	$146.20	$342.75	$314.92
85+	$204.81	$391.11	$363.98	$391.29	$154.50	$364.15	$335.98

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.

***Region 6– OH counties: Mahoning, Trumbull**

FEMALE

AGE	PLAN A	PLAN C	PLAN D	PLAN F	PLAN FHD	PLAN G	PLAN N
65	$117.63	$161.35	$144.90	$161.46	$65.81	$145.01	$128.71
66	$121.56	$168.72	$151.74	$168.84	$68.66	$151.85	$135.00
67	$125.48	$176.10	$158.57	$176.22	$71.51	$158.69	$141.28
68	$129.41	$183.48	$165.41	$183.60	$74.36	$165.53	$147.57
69	$133.34	$190.86	$172.25	$190.98	$77.21	$172.37	$153.85
70	$137.26	$198.23	$179.09	$198.36	$80.05	$179.21	$160.14
71	$141.19	$205.61	$185.92	$205.74	$82.90	$186.05	$166.42
72	$145.12	$212.99	$192.76	$213.12	$85.75	$192.89	$172.71
73	$148.47	$221.29	$200.64	$221.42	$88.95	$200.77	$180.13
74	$151.82	$229.59	$208.52	$229.73	$92.16	$208.66	$187.55
75	$155.17	$237.89	$216.39	$238.03	$95.36	$216.54	$194.97
76	$158.52	$246.18	$224.27	$246.33	$98.56	$224.42	$202.39
77	$161.87	$254.48	$232.15	$254.63	$101.77	$232.30	$209.81
78	$164.39	$264.03	$241.45	$264.18	$105.45	$241.60	$218.79
79	$166.91	$273.58	$250.75	$273.73	$109.14	$250.90	$227.76
80	$169.42	$283.13	$260.05	$283.29	$112.83	$260.20	$236.74
81	$171.94	$292.68	$269.35	$292.84	$116.51	$269.50	$245.72
82	$174.46	$302.23	$278.64	$302.39	$120.20	$278.80	$254.70
83	$175.02	$321.83	$298.52	$321.98	$127.76	$298.67	$274.63
84	$175.59	$341.42	$318.40	$341.57	$135.32	$318.55	$294.55
85+	$176.16	$361.02	$338.28	$361.16	$142.88	$338.43	$314.48

MEDICARE SUPPLEMENT

Monthly Premium Rates Region 7*

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.

MALE

AGE	PLAN A	PLAN C	PLAN D	PLAN F	PLAN FHD	PLAN G	PLAN N
65	$115.10	$158.78	$143.37	$158.88	$64.83	$143.46	$128.56
66	$120.87	$167.95	$151.74	$168.05	$68.37	$151.84	$136.15
67	$126.64	$177.12	$160.11	$177.22	$71.91	$160.21	$143.74
68	$132.42	$186.28	$168.48	$186.39	$75.45	$168.59	$151.33
69	$138.19	$195.45	$176.85	$195.56	$78.99	$176.96	$158.93
70	$143.96	$204.61	$185.21	$204.73	$82.53	$185.33	$166.52
71	$149.73	$213.78	$193.58	$213.90	$86.07	$193.71	$174.11
72	$155.51	$222.95	$201.95	$223.07	$89.61	$202.08	$181.70
73	$160.86	$233.06	$211.35	$233.19	$93.51	$211.48	$190.39
74	$166.22	$243.17	$220.75	$243.31	$97.41	$220.88	$199.07
75	$171.57	$253.29	$230.15	$253.43	$101.32	$230.28	$207.75
76	$176.93	$263.40	$239.54	$263.54	$105.22	$239.69	$216.43
77	$182.28	$273.51	$248.94	$273.66	$109.13	$249.09	$225.11
78	$185.89	$283.57	$258.57	$283.73	$113.01	$258.72	$234.26
79	$189.50	$293.64	$268.20	$293.79	$116.89	$268.35	$243.41
80	$193.11	$303.70	$277.83	$303.85	$120.78	$277.98	$252.57
81	$196.72	$313.76	$287.45	$313.92	$124.66	$287.61	$261.72
82	$200.33	$323.82	$297.08	$323.98	$128.54	$297.24	$270.87
83	$202.85	$343.32	$316.46	$343.48	$136.07	$316.62	$289.94
84	$205.37	$362.81	$335.84	$362.97	$143.59	$336.00	$309.02
85+	$207.89	$382.31	$355.22	$382.47	$151.11	$355.38	$328.09

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.

***Region 7–OH counties: Ashland, Columbiana, Coshocton, Guernsey, Harrison, Holmes, Monroe, Muskingum, Noble, Tuscarawas, Washington, Wayne**

FEMALE

AGE	PLAN A	PLAN C	PLAN D	PLAN F	PLAN FHD	PLAN G	PLAN N
65	$122.06	$163.90	$147.43	$164.00	$66.81	$147.53	$131.67
66	$126.05	$171.13	$154.13	$171.23	$69.60	$154.23	$137.83
67	$130.05	$178.36	$160.82	$178.46	$72.39	$160.92	$143.98
68	$134.05	$185.59	$167.51	$185.70	$75.18	$167.62	$150.14
69	$138.05	$192.82	$174.20	$192.93	$77.97	$174.31	$156.29
70	$142.04	$200.05	$180.89	$200.16	$80.76	$181.01	$162.45
71	$146.04	$207.28	$187.58	$207.40	$83.56	$187.70	$168.60
72	$150.04	$214.51	$194.27	$214.63	$86.35	$194.39	$174.76
73	$153.36	$222.43	$201.78	$222.56	$89.41	$201.90	$181.83
74	$156.68	$230.36	$209.29	$230.49	$92.47	$209.42	$188.89
75	$160.01	$238.29	$216.80	$238.42	$95.53	$216.93	$195.96
76	$163.33	$246.22	$224.31	$246.35	$98.59	$224.44	$203.03
77	$166.65	$254.15	$231.82	$254.28	$101.65	$231.95	$210.10
78	$169.00	$263.01	$240.43	$263.15	$105.07	$240.57	$218.41
79	$171.35	$271.88	$249.05	$272.01	$108.49	$249.19	$226.72
80	$173.70	$280.74	$257.67	$280.88	$111.91	$257.80	$235.03
81	$176.05	$289.61	$266.28	$289.75	$115.33	$266.42	$243.35
82	$178.40	$298.47	$274.90	$298.61	$118.75	$275.04	$251.66
83	$178.16	$315.77	$292.50	$315.91	$125.43	$292.64	$269.33
84	$177.92	$333.08	$310.10	$333.21	$132.11	$310.23	$287.00
85+	$177.68	$350.38	$327.70	$350.51	$138.78	$327.83	$304.67

MEDICARE SUPPLEMENT

Monthly Premium Rates Region 8*

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.

MALE

AGE	PLAN A	PLAN C	PLAN D	PLAN F	PLAN FHD	PLAN G	PLAN N
65	$108.88	$150.64	$135.26	$150.82	$61.74	$135.45	$121.02
66	$114.33	$159.30	$143.13	$159.49	$65.09	$143.32	$128.15
67	$119.78	$167.96	$151.00	$168.16	$68.44	$151.20	$135.27
68	$125.23	$176.62	$158.87	$176.84	$71.78	$159.08	$142.39
69	$130.69	$185.29	$166.74	$185.51	$75.13	$166.95	$149.51
70	$136.14	$193.95	$174.60	$194.18	$78.48	$174.83	$156.63
71	$141.59	$202.61	$182.47	$202.85	$81.82	$182.71	$163.76
72	$147.04	$211.28	$190.34	$211.52	$85.17	$190.59	$170.88
73	$152.11	$220.82	$199.17	$221.08	$88.85	$199.43	$179.02
74	$157.18	$230.36	$208.00	$230.63	$92.54	$208.26	$187.17
75	$162.25	$239.91	$216.83	$240.18	$96.23	$217.10	$195.31
76	$167.31	$249.45	$225.66	$249.73	$99.91	$225.94	$203.45
77	$172.38	$258.99	$234.49	$259.28	$103.60	$234.78	$211.59
78	$175.82	$268.47	$243.53	$268.76	$107.26	$243.83	$220.18
79	$179.26	$277.94	$252.57	$278.24	$110.91	$252.87	$228.77
80	$182.70	$287.41	$261.62	$287.71	$114.57	$261.92	$237.35
81	$186.13	$296.88	$270.66	$297.19	$118.22	$270.96	$245.94
82	$189.57	$306.35	$279.70	$306.66	$121.88	$280.01	$254.52
83	$192.06	$324.64	$297.87	$324.95	$128.94	$298.18	$272.41
84	$194.55	$342.93	$316.05	$343.24	$136.00	$316.36	$290.30
85+	$197.04	$361.21	$334.22	$361.53	$143.05	$334.54	$308.19

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.

***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**

FEMALE

AGE	PLAN A	PLAN C	PLAN D	PLAN F	PLAN FHD	PLAN G	PLAN N
65	$115.41	$155.52	$139.10	$155.72	$63.63	$139.29	$123.95
66	$119.19	$162.35	$145.39	$162.55	$66.27	$145.59	$129.72
67	$122.97	$169.17	$151.68	$169.38	$68.91	$151.88	$135.49
68	$126.75	$176.00	$157.96	$176.21	$71.54	$158.18	$141.27
69	$130.53	$182.82	$164.25	$183.04	$74.18	$164.47	$147.04
70	$134.31	$189.65	$170.54	$189.87	$76.81	$170.77	$152.82
71	$138.10	$196.47	$176.83	$196.70	$79.45	$177.06	$158.59
72	$141.88	$203.30	$183.12	$203.54	$82.09	$183.36	$164.36
73	$145.03	$210.77	$190.17	$211.01	$84.97	$190.41	$170.99
74	$148.19	$218.24	$197.22	$218.48	$87.85	$197.47	$177.62
75	$151.35	$225.71	$204.27	$225.96	$90.74	$204.53	$184.25
76	$154.50	$233.18	$211.33	$233.43	$93.62	$211.58	$190.88
77	$157.66	$240.64	$218.38	$240.91	$96.51	$218.64	$197.51
78	$159.91	$248.98	$226.47	$249.24	$99.72	$226.73	$205.31
79	$162.17	$257.31	$234.55	$257.58	$102.94	$234.82	$213.11
80	$164.42	$265.64	$242.64	$265.91	$106.16	$242.91	$220.90
81	$166.68	$273.97	$250.73	$274.25	$109.37	$251.00	$228.70
82	$168.93	$282.31	$258.82	$282.58	$112.59	$259.09	$236.50
83	$168.83	$298.50	$275.31	$298.77	$118.84	$275.58	$253.07
84	$168.72	$314.70	$291.81	$314.96	$125.08	$292.08	$269.64
85+	$168.62	$330.89	$308.31	$331.16	$131.33	$308.57	$286.21

MEDICARE SUPPLEMENT

Monthly Premium Rates Region 9*

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.

MALE

AGE	PLAN A	PLAN C	PLAN D	PLAN F	PLAN FHD	PLAN G	PLAN N
65	$113.06	$157.17	$141.77	$157.27	$64.20	$141.87	$126.89
66	$118.79	$166.34	$150.14	$166.45	$67.74	$150.24	$134.48
67	$124.52	$175.51	$158.51	$175.62	$71.28	$158.62	$142.07
68	$130.25	$184.68	$166.89	$184.80	$74.82	$167.00	$149.67
69	$135.98	$193.85	$175.26	$193.97	$78.36	$175.38	$157.26
70	$141.72	$203.02	$183.63	$203.15	$81.90	$183.75	$164.85
71	$147.45	$212.19	$192.00	$212.32	$85.44	$192.13	$172.44
72	$153.18	$221.36	$200.38	$221.50	$88.98	$200.51	$180.03
73	$158.59	$231.61	$209.91	$231.75	$92.94	$210.04	$188.84
74	$164.01	$241.85	$219.44	$242.00	$96.89	$219.58	$197.65
75	$169.42	$252.10	$228.97	$252.25	$100.85	$229.11	$206.45
76	$174.84	$262.35	$238.49	$262.49	$104.80	$238.64	$215.26
77	$180.25	$272.59	$248.02	$272.74	$108.76	$248.18	$224.07
78	$184.10	$283.00	$258.00	$283.16	$112.78	$258.15	$233.56
79	$187.95	$293.41	$267.97	$293.57	$116.80	$268.13	$243.05
80	$191.79	$303.82	$277.95	$303.98	$120.81	$278.11	$252.54
81	$195.64	$314.23	$287.92	$314.40	$124.83	$288.09	$262.03
82	$199.48	$324.64	$297.90	$324.81	$128.85	$298.06	$271.53
83	$202.92	$345.38	$318.51	$345.54	$136.85	$318.67	$291.81
84	$206.37	$366.11	$339.12	$366.28	$144.85	$339.28	$312.10
85+	$209.81	$386.84	$359.73	$387.01	$152.85	$359.89	$332.38

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.

***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**

FEMALE

AGE	PLAN A	PLAN C	PLAN D	PLAN F	PLAN FHD	PLAN G	PLAN N
65	$119.61	$161.82	$145.37	$161.92	$65.99	$145.47	$129.54
66	$123.63	$169.12	$152.13	$169.23	$68.81	$152.24	$135.76
67	$127.65	$176.42	$158.89	$176.53	$71.63	$159.00	$141.99
68	$131.67	$183.73	$165.66	$183.84	$74.45	$165.77	$148.21
69	$135.70	$191.03	$172.42	$191.15	$77.27	$172.54	$154.44
70	$139.72	$198.33	$179.18	$198.45	$80.09	$179.30	$160.66
71	$143.74	$205.64	$185.95	$205.76	$82.91	$186.07	$166.88
72	$147.76	$212.94	$192.71	$213.07	$85.73	$192.84	$173.11
73	$151.22	$221.08	$200.43	$221.21	$88.87	$200.56	$180.38
74	$154.68	$229.22	$208.16	$229.36	$92.02	$208.29	$187.66
75	$158.14	$237.37	$215.88	$237.50	$95.16	$216.01	$194.93
76	$161.61	$245.51	$223.60	$245.65	$98.30	$223.74	$202.21
77	$165.07	$253.65	$231.32	$253.79	$101.45	$231.46	$209.48
78	$167.71	$262.93	$240.35	$263.07	$105.03	$240.49	$218.20
79	$170.35	$272.20	$249.37	$272.35	$108.61	$249.52	$226.91
80	$173.00	$281.48	$258.40	$281.62	$112.19	$258.54	$235.63
81	$175.64	$290.76	$267.43	$290.90	$115.77	$267.57	$244.34
82	$178.29	$300.03	$276.45	$300.18	$119.35	$276.60	$253.06
83	$179.12	$318.75	$295.46	$318.89	$126.57	$295.60	$272.11
84	$179.95	$337.46	$314.46	$337.60	$133.79	$314.60	$291.17
85+	$180.79	$356.17	$333.46	$356.31	$141.01	$333.60	$310.22

MEDICARE SUPPLEMENT

Monthly Premium Rates Region 10*

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.

MALE

AGE	PLAN A	PLAN C	PLAN D	PLAN F	PLAN FHD	PLAN G	PLAN N
65	$103.50	$143.19	$128.58	$143.36	$58.69	$128.75	$115.04
66	$108.68	$151.42	$136.06	$151.61	$61.87	$136.24	$121.81
67	$113.86	$159.66	$143.54	$159.85	$65.05	$143.73	$128.58
68	$119.04	$167.89	$151.01	$168.09	$68.23	$151.21	$135.35
69	$124.23	$176.13	$158.49	$176.34	$71.42	$158.70	$142.12
70	$129.41	$184.36	$165.97	$184.58	$74.60	$166.19	$148.89
71	$134.59	$192.60	$173.45	$192.82	$77.78	$173.68	$155.66
72	$139.77	$200.83	$180.93	$201.07	$80.96	$181.17	$162.43
73	$144.59	$209.90	$189.32	$210.15	$84.46	$189.57	$170.17
74	$149.41	$218.98	$197.72	$219.23	$87.97	$197.97	$177.91
75	$154.23	$228.05	$206.11	$228.31	$91.47	$206.37	$185.65
76	$159.04	$237.12	$214.51	$237.39	$94.97	$214.77	$193.39
77	$163.86	$246.19	$222.90	$246.47	$98.48	$223.18	$201.14
78	$167.13	$255.19	$231.50	$255.47	$101.95	$231.77	$209.30
79	$170.40	$264.20	$240.09	$264.48	$105.43	$240.37	$217.46
80	$173.66	$273.20	$248.68	$273.49	$108.90	$248.97	$225.62
81	$176.93	$282.20	$257.28	$282.50	$112.38	$257.57	$233.78
82	$180.20	$291.21	$265.87	$291.50	$115.86	$266.17	$241.94
83	$182.56	$308.59	$283.15	$308.89	$122.56	$283.44	$258.94
84	$184.93	$325.97	$300.42	$326.27	$129.27	$300.72	$275.95
85+	$187.30	$343.36	$317.70	$343.66	$135.98	$318.00	$292.95

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.

***Region 10–WV counties: Boone, Clay, Kanawha**

FEMALE

AGE	PLAN A	PLAN C	PLAN D	PLAN F	PLAN FHD	PLAN G	PLAN N
65	$109.70	$147.83	$132.22	$148.02	$60.49	$132.41	$117.82
66	$113.30	$154.32	$138.20	$154.51	$62.99	$138.39	$123.31
67	$116.89	$160.81	$144.18	$161.01	$65.50	$144.38	$128.80
68	$120.49	$167.30	$150.16	$167.50	$68.01	$150.36	$134.28
69	$124.08	$173.78	$156.13	$173.99	$70.51	$156.34	$139.77
70	$127.68	$180.27	$162.11	$180.49	$73.02	$162.32	$145.26
71	$131.27	$186.76	$168.09	$186.98	$75.52	$168.31	$150.75
72	$134.86	$193.25	$174.07	$193.47	$78.03	$174.29	$156.24
73	$137.86	$200.35	$180.77	$200.58	$80.77	$181.00	$162.54
74	$140.86	$207.45	$187.47	$207.68	$83.51	$187.71	$168.84
75	$143.87	$214.55	$194.18	$214.79	$86.25	$194.42	$175.15
76	$146.87	$221.65	$200.88	$221.89	$89.00	$201.12	$181.45
77	$149.87	$228.75	$207.58	$229.00	$91.74	$207.83	$187.75
78	$152.01	$236.67	$215.27	$236.92	$94.79	$215.52	$195.16
79	$154.15	$244.59	$222.96	$244.84	$97.85	$223.21	$202.57
80	$156.29	$252.51	$230.65	$252.77	$100.91	$230.90	$209.98
81	$158.44	$260.43	$238.33	$260.69	$103.97	$238.59	$217.39
82	$160.58	$268.35	$246.02	$268.61	$107.02	$246.28	$224.81
83	$160.48	$283.75	$261.70	$284.00	$112.96	$261.96	$240.56
84	$160.38	$299.14	$277.39	$299.40	$118.90	$277.64	$256.31
85+	$160.28	$314.54	$293.07	$314.79	$124.84	$293.31	$272.07

MEDICARE SUPPLEMENT

Monthly Premium Rates Region 11*

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.

MALE

AGE	PLAN A	PLAN C	PLAN D	PLAN F	PLAN FHD	PLAN G	PLAN N
65	$102.53	$141.85	$127.37	$142.02	$58.14	$127.54	$113.96
66	$107.66	$150.01	$134.78	$150.19	$61.29	$134.96	$120.67
67	$112.79	$158.16	$142.19	$158.35	$64.44	$142.38	$127.38
68	$117.93	$166.32	$149.60	$166.52	$67.60	$149.80	$134.08
69	$123.06	$174.48	$157.01	$174.69	$70.75	$157.22	$140.79
70	$128.20	$182.64	$164.42	$182.85	$73.90	$164.63	$147.50
71	$133.33	$190.79	$171.83	$191.02	$77.05	$172.05	$154.20
72	$138.46	$198.95	$179.24	$199.18	$80.20	$179.47	$160.91
73	$143.24	$207.94	$187.55	$208.18	$83.67	$187.79	$168.58
74	$148.01	$216.92	$195.87	$217.17	$87.14	$196.12	$176.25
75	$152.78	$225.91	$204.18	$226.17	$90.61	$204.44	$183.92
76	$157.55	$234.90	$212.50	$235.16	$94.08	$212.76	$191.58
77	$162.33	$243.89	$220.81	$244.16	$97.56	$221.09	$199.25
78	$165.56	$252.80	$229.33	$253.08	$101.00	$229.60	$207.34
79	$168.80	$261.72	$237.84	$262.01	$104.44	$238.12	$215.42
80	$172.04	$270.64	$246.35	$270.93	$107.89	$246.64	$223.50
81	$175.27	$279.56	$254.87	$279.85	$111.33	$255.16	$231.59
82	$178.51	$288.48	$263.38	$288.77	$114.77	$263.67	$239.67
83	$180.85	$305.70	$280.50	$306.00	$121.42	$280.79	$256.52
84	$183.20	$322.92	$297.61	$323.22	$128.06	$297.91	$273.36
85+	$185.54	$340.14	$314.73	$340.44	$134.71	$315.02	$290.21

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.

***Region 11–WV counties: Monongalia, Preston**

FEMALE

AGE	PLAN A	PLAN C	PLAN D	PLAN F	PLAN FHD	PLAN G	PLAN N
65	$108.68	$146.45	$130.99	$146.63	$59.92	$131.17	$116.72
66	$112.24	$152.88	$136.91	$153.07	$62.40	$137.10	$122.15
67	$115.80	$159.30	$142.83	$159.50	$64.89	$143.02	$127.59
68	$119.36	$165.73	$148.75	$165.93	$67.37	$148.95	$133.03
69	$122.92	$172.16	$154.67	$172.36	$69.85	$154.88	$138.46
70	$126.48	$178.58	$160.59	$178.80	$72.33	$160.80	$143.90
71	$130.04	$185.01	$166.51	$185.23	$74.82	$166.73	$149.34
72	$133.60	$191.44	$172.44	$191.66	$77.30	$172.66	$154.78
73	$136.57	$198.47	$179.08	$198.70	$80.01	$179.30	$161.02
74	$139.55	$205.51	$185.72	$205.74	$82.73	$185.95	$167.26
75	$142.52	$212.54	$192.36	$212.78	$85.45	$192.60	$173.50
76	$145.49	$219.57	$199.00	$219.82	$88.16	$199.24	$179.75
77	$148.46	$226.61	$205.64	$226.85	$90.88	$205.89	$185.99
78	$150.59	$234.45	$213.26	$234.70	$93.91	$213.50	$193.33
79	$152.71	$242.30	$220.87	$242.55	$96.94	$221.12	$200.67
80	$154.83	$250.15	$228.49	$250.40	$99.96	$228.74	$208.02
81	$156.95	$257.99	$236.10	$258.25	$102.99	$236.36	$215.36
82	$159.08	$265.84	$243.72	$266.10	$106.02	$243.98	$222.70
83	$158.98	$281.09	$259.25	$281.34	$111.90	$259.51	$238.31
84	$158.88	$296.34	$274.79	$296.59	$117.79	$275.04	$253.91
85+	$158.78	$311.59	$290.32	$311.84	$123.67	$290.57	$269.52

MEDICARE SUPPLEMENT

Monthly Premium Rates Region 12*

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.

MALE

AGE	PLAN A	PLAN C	PLAN D	PLAN F	PLAN FHD	PLAN G	PLAN N
65	$90.84	$125.68	$112.85	$125.83	$51.51	$113.00	$100.97
66	$95.39	$132.91	$119.42	$133.07	$54.31	$119.58	$106.91
67	$99.94	$140.13	$125.98	$140.30	$57.10	$126.15	$112.86
68	$104.48	$147.36	$132.55	$147.54	$59.89	$132.72	$118.80
69	$109.03	$154.59	$139.11	$154.77	$62.68	$139.29	$124.74
70	$113.58	$161.82	$145.67	$162.01	$65.47	$145.86	$130.68
71	$118.13	$169.04	$152.24	$169.24	$68.27	$152.44	$136.62
72	$122.68	$176.27	$158.80	$176.48	$71.06	$159.01	$142.57
73	$126.91	$184.23	$166.17	$184.45	$74.13	$166.38	$149.36
74	$131.14	$192.20	$173.54	$192.42	$77.21	$173.76	$156.15
75	$135.36	$200.16	$180.91	$200.39	$80.28	$181.13	$162.95
76	$139.59	$208.12	$188.27	$208.35	$83.36	$188.51	$169.74
77	$143.82	$216.08	$195.64	$216.32	$86.43	$195.88	$176.54
78	$146.69	$223.98	$203.18	$224.23	$89.48	$203.43	$183.70
79	$149.56	$231.89	$210.73	$232.14	$92.54	$210.97	$190.86
80	$152.43	$239.79	$218.27	$240.04	$95.59	$218.52	$198.02
81	$155.29	$247.69	$225.81	$247.95	$98.64	$226.07	$205.19
82	$158.16	$255.59	$233.35	$255.85	$101.69	$233.61	$212.35
83	$160.24	$270.85	$248.52	$271.11	$107.58	$248.78	$227.28
84	$162.31	$286.11	$263.68	$286.37	$113.46	$263.94	$242.20
85+	$164.39	$301.36	$278.85	$301.63	$119.35	$279.11	$257.13

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.

***Region 12–WV counties: Hampshire**

FEMALE

AGE	PLAN A	PLAN C	PLAN D	PLAN F	PLAN FHD	PLAN G	PLAN N
65	$96.29	$129.75	$116.05	$129.92	$53.09	$116.22	$103.41
66	$99.44	$135.45	$121.30	$135.62	$55.29	$121.47	$108.23
67	$102.60	$141.14	$126.55	$141.32	$57.49	$126.72	$113.04
68	$105.75	$146.84	$131.79	$147.01	$59.69	$131.97	$117.86
69	$108.91	$152.53	$137.04	$152.71	$61.89	$137.22	$122.68
70	$112.06	$158.22	$142.28	$158.41	$64.09	$142.47	$127.50
71	$115.22	$163.92	$147.53	$164.11	$66.29	$147.72	$132.31
72	$118.37	$169.61	$152.78	$169.81	$68.49	$152.98	$137.13
73	$121.00	$175.85	$158.66	$176.05	$70.89	$158.86	$142.66
74	$123.64	$182.08	$164.54	$182.28	$73.30	$164.75	$148.19
75	$126.27	$188.31	$170.43	$188.52	$75.70	$170.64	$153.72
76	$128.90	$194.54	$176.31	$194.76	$78.11	$176.53	$159.26
77	$131.54	$200.77	$182.20	$200.99	$80.52	$182.41	$164.79
78	$133.42	$207.73	$188.94	$207.95	$83.20	$189.16	$171.29
79	$135.30	$214.68	$195.69	$214.90	$85.88	$195.91	$177.80
80	$137.18	$221.63	$202.44	$221.85	$88.57	$202.66	$184.30
81	$139.06	$228.58	$209.19	$228.81	$91.25	$209.41	$190.81
82	$140.94	$235.53	$215.93	$235.76	$93.93	$216.16	$197.31
83	$140.85	$249.05	$229.70	$249.27	$99.15	$229.92	$211.14
84	$140.77	$262.56	$243.46	$262.78	$104.36	$243.68	$224.97
85+	$140.68	$276.07	$257.23	$276.29	$109.57	$257.44	$238.79

Outline of
Medicare Supplement Plan Coverage

PREMIUM INFORMATION

You may keep your plan in force by paying the required monthly premium when due. Monthly rates shown reflect current premium levels and all rates are subject to change. Any change will apply to all members of the same class insured under your plan who reside in your state/region. Your premium can only be changed with the approval of The Health Plan and/or your state insurance department.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY CAREFULLY

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

RIGHT TO RETURN POLICY

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

THP Insurance Company
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 health coverage 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.

WARNING: IF YOU OR YOUR FAMILY MEMBER ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. BEFORE YOU ENROLL IN THIS PLAN, READ ALL OF THE RULES VERY CAREFULLY AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

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Benefit Plan **Summaries**

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

Plan A

*A Benefit Period begins on the 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.

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

MEDICARE PAYS	PLAN A PAYS	YOU PAY UNDER PLAN A
Semi-private room and board, general nursing and miscellaneous services and supplies.		
All but $1,364	$0	$1,364 (Part A Deductible)
All but $341 a day	$341 a day	$0
All but $682 a day $0	$682 a day 100% of Medicare eligible expenses	$0 $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 $170.50 a day	$0	Up to $170.50 a day
$0	$0	All costs
$0	3 pints	$0
100%	$0	$0
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		
All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare copay/ coinsurance	$0

MEDICARE (PART B) MEDICAL SERVICES
PER CALENDAR YEAR

Plan A

*Once you have been billed $185 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 $185 of Medicare-approved amounts
Remainder of Medicare-approved amounts
Part B excess charges (above Medicare-approved amounts)
BLOOD
First 3 pints
Next $185 of Medicare-approved amounts*
Remainder of Medicare-approved amounts
CLINICAL LABORATORY SERVICES

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	$185 (Part B Deductible)
Generally 80%	Generally 20%	$0
$0	$0	All costs
$0	All costs	$0
$0	$0	$185 (Part B Deductible)
80%	20%	$0
Tests for diagnostic services.		
100%	$0	$0

Plan A

*Once you have been billed $185 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 $185 of Medicare-approved amounts*
Remainder of Medicare-approved amounts

MEDICARE PAYS	PLAN A PAYS	YOU PAY UNDER PLAN A
(Medicare-approved services)		
100%	$0	$0
$0	$0	$185 (Part B Deductible)
80%	20%	$0

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

Plan C

*A Benefit Period begins on the 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.

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

MEDICARE PAYS	PLAN C PAYS	YOU PAY UNDER PLAN C
Semi-private room and board, general nursing and miscellaneous services and supplies.		
All but $1,364	$1,364 (Part A Deductible)	$0
All but $341 a day	$341 a day	$0
All but $682 a day $0	$682 a day 100% of Medicare eligible expenses	$0 $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 $170.50 a day	Up to $170.50 a day	$0
$0	$0	All costs
$0	3 pints	$0
100%	$0	$0
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		
All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare copay/ coinsurance	$0

MEDICARE (PART B) MEDICAL SERVICES
PER CALENDAR YEAR

Plan C

SERVICES
MEDICAL EXPENSES
First $185 of Medicare-approved amounts
Remainder of Medicare-approved amounts
Part B excess charges (above Medicare-approved amounts)
BLOOD
First 3 pints
Next $185 of Medicare-approved amounts*
Remainder of Medicare-approved amounts
CLINICAL LABORATORY SERVICES

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	$185 (Part B Deductible)	$0
Generally 80%	Generally 20%	$0
$0	$0	All costs
$0	All Costs	$0
$0	$185 (Part B Deductible)	$0
80%	20%	$0
Tests for diagnostic services.		
100%	$0	$0

Plan C

SERVICES
HOME HEALTH CARE
Medically necessary skilled care services and medical supplies
DURABLE MEDICAL EQUIPMENT
First $185 of Medicare-approved amount*
Remainder of Medicare-approved amounts
FOREIGN TRAVEL
First $250 each calendar year
Remainder of charges

MEDICARE PAYS	PLAN C PAYS	YOU PAY UNDER PLAN C
(Medicare-approved services)		
100%	$0	$0
$0	$185 (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

Plan D

*A Benefit Period begins on the 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.

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

MEDICARE PAYS	PLAN D PAYS	YOU PAY UNDER PLAN D
Semi-private room and board, general nursing and miscellaneous services and supplies.		
All but $1,364	$1,364 (Part A Deductible)	$0
All but $341 a day	$341 a day	$0
All but $682 a day $0	$682 a day 100% of Medicare eligible expenses	$0 $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 $170.50 a day	Up to $170.50 a day	$0
$0	$0	All costs
$0	3 pints	$0
100%	$0	$0
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		
All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare copay/ coinsurance	$0

MEDICARE (PART B) MEDICAL SERVICES
PER CALENDAR YEAR

Plan D

*Once you have been billed $185 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 $185 of Medicare-approved amounts
Remainder of Medicare-approved amounts
Part B excess charges (above Medicare-approved amounts)
BLOOD
First 3 pints
Next $185 of Medicare-approved amounts*
Remainder of Medicare-approved amounts
CLINICAL LABORATORY SERVICES

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	$185 (Part B Deductible)
Generally 80%	Generally 20%	$0
$0	$0	All costs
$0	All costs	$0
$0	$0	$185 (Part B Deductible)
80%	20%	$0
Tests for diagnostic services.		
100%	$0	$0

Plan D

*Once you have been billed $185 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 $185 of Medicare-approved amounts*	
Remainder of Medicare-approved amounts	
FOREIGN TRAVEL	
First $250 each calendar year	
Remainder of charges	

MEDICARE PAYS	PLAN D PAYS	YOU PAY UNDER PLAN D
(Medicare-approved services)		
100%	$0	$0
$0	$0	$185 (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

Plan F

or High-Deductible Plan F

*A Benefit Period begins on the 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.

**The Plan F high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,300 deductible. Benefits from the high-deductible Plan F will not begin until out-of-pocket expenses are $2,300. 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 on any difference between its billed charges and the amount Medicare would have paid.

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

MEDICARE PAYS	AFTER YOU PAY $2,300 DEDUCTIBLE,** PLAN F PAYS	IN ADDITION TO $2,300 DEDUCTIBLE, **YOU PAY UNDER PLAN F
Semi-private room and board, general nursing and miscellaneous services and supplies.		
All but $1,364	$1,364 (Part A Deductible)	$0
All but $341 a day	$341 a day	$0
All but $682 a day $0	$682 a day 100% of Medicare eligible expenses	$0 $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 $170.50 a day	Up to $170.50 a day	$0
$0	$0	All costs
$0	3 pints	$0
100%	$0	$0
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		
All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare copay/ coinsurance	$0

MEDICARE (PART B) MEDICAL SERVICES
PER CALENDAR YEAR

Plan F

or High-Deductible Plan F

**The Plan F high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,300 deductible. Benefits from the high-deductible Plan F will not begin until out-of-pocket expenses are $2,300. 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 $185 of Medicare-approved amounts
Remainder of Medicare-approved amounts
Part B excess charges (above Medicare-approved amounts)
BLOOD
First 3 pints
Next $185 of Medicare-approved amounts*
Remainder of Medicare-approved amounts
CLINICAL LABORATORY SERVICES

MEDICARE PAYS	AFTER YOU PAY $2,300 DEDUCTIBLE,** PLAN F PAYS	IN ADDITION TO $2,300 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	$185 (Part B Deductible)	$0
Generally 80%	Generally 20%	$0
$0	100%	$0
$0	All costs	$0
$0	$185 (Part B Deductible)	$0
80%	20%	$0
Tests for diagnostic services.		
100%	$0	$0

Plan F

or High-Deductible Plan F

**The Plan F high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,300 deductible. Benefits from the high-deductible Plan F will not begin until out-of-pocket expenses are $2,300. 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 $185 of Medicare-approved amounts*
Remainder of Medicare-approved amounts
FOREIGN TRAVEL
First $250 each calendar year
Remainder of charges

MEDICARE PAYS	AFTER YOU PAY $2,300 DEDUCTIBLE,** PLAN F PAYS	IN ADDITION TO $2,300 DEDUCTIBLE, **YOU PAY UNDER PLAN F
(Medicare-approved services)		
100%	$0	$0
$0	$185 (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

Plan G

*A Benefit Period begins on the 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.

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

MEDICARE PAYS	PLAN G PAYS	YOU PAY UNDER PLAN G
Semi-private room and board, general nursing and miscellaneous services and supplies.		
All but $1,364	$1,364 (Part A Deductible)	$0
All but $341 a day	$341 a day	$0
All but $682 a day $0	$682 a day 100% of Medicare eligible expenses	$0 $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 $170.50 a day	Up to $170.50 a day	$0
$0	$0	All costs
$0	3 pints	$0
100%	$0	$0
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		
All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare copay/ coinsurance	$0

MEDICARE (PART B) MEDICAL SERVICES
PER CALENDAR YEAR

Plan G

*Once you have been billed $185 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 $185 of Medicare-approved amounts
Remainder of Medicare-approved amounts
Part B excess charges (above Medicare-approved amounts)
BLOOD
First 3 pints
Next $185 of Medicare-approved amounts*
Remainder of Medicare-approved amounts
CLINICAL LABORATORY SERVICES

MEDICARE PAYS	PLAN G PAYS	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	$185 (Part B Deductible)
Generally 80%	Generally 20%	$0
$0	100%	$0
$0	All costs	$0
$0	$0	$185 (Part B Deductible)
80%	20%	$0
Tests for diagnostic services.		
100%	$0	$0

Plan G

*Once you have been billed $185 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 $185 of Medicare-approved amounts*	
Remainder of Medicare-approved amounts	
FOREIGN TRAVEL	
First $250 each calendar year	
Remainder of charges	

MEDICARE PAYS	PLAN G PAYS	YOU PAY UNDER PLAN G
(Medicare-approved services)		
100%	$0	$0
$0	$0	$185 (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

Plan N

*A Benefit Period begins on the 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.

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

MEDICARE PAYS	PLAN N PAYS	YOU PAY UNDER PLAN N
Semi-private room and board, general nursing and miscellaneous services and supplies.		
All but $1,364	$1,364 (Part A Deductible)	$0
All but $341 a day	$341 a day	$0
All but $682 a day $0	$682 a day 100% of Medicare eligible expenses	$0 $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 $170.50 a day	Up to $170.50 a day	$0
$0	$0	All costs
$0	3 pints	$0
100%	$0	$0
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		
All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare copay/ coinsurance	$0

MEDICARE (PART B) MEDICAL SERVICES
PER CALENDAR YEAR

Plan N

*Once you have been billed $185 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 $185 of Medicare-approved amounts
Remainder of Medicare-approved amounts
Part B excess charges (above Medicare-approved amounts)
BLOOD
First 3 pints
Next $185 of Medicare-approved amounts*
Remainder of Medicare-approved amounts
CLINICAL LABORATORY SERVICES

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	$185 (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.
$0	$0	All costs
$0	All costs	$0
$0	$0	$185 (Part B Deductible)
80%	20%	$0
Tests for diagnostic services.		
100%	$0	$0

Plan N

*Once you have been billed $185 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 $185 of Medicare-approved amounts*	
Remainder of Medicare-approved amounts	
FOREIGN TRAVEL	
First $250 each calendar year	
Remainder of charges	

MEDICARE PAYS	PLAN N PAYS	YOU PAY UNDER PLAN N
(Medicare-approved services)		
100%	$0	$0
$0	$0	$185 (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 Supplement
Insurance Policies

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

* 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.

FORM#

OH: OHTHP-85 WV: WVTHP-55

BENEFIT	MEDICARE PAYS
MEDICARE PART A HOSPITAL CARE	
First 60 days	All but $1,364 (Part A deductible)
Days 61-90	All but $341 a day
Days 91-150: while using 60 lifetime reserve days	All but $682 a day
Once lifetime reserve days are used: additional 365 days	$0
Beyond the additional 365 days	$0
Blood – first 3 pints	$0
Blood – additional amounts	100%
SKILLED NURSING FACILITY CARE	
First 20 days	All approved amounts
Days 21 - 100	All but $170.50 a day
Days 101 and after	$0
HOSPICE CARE	
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care

THP MEDICARE SUPPLEMENT INSURANCE POLICIES PAY

PLAN A	PLAN C PLAN D	PLAN F** PLAN G	PLAN N
$0	$1,364 (Part A deductible)	$1,364 (Part A deductible)	$1,364 (Part A deductible)
$341 a day			
$682 a day			
100% of Medicare eligible expenses			
$0			
First 3 pints			
$0			
$0			
$0	Up to $170.50 a day		
$0			
Medicare copayment/coinsurance			

Medicare Supplement **Insurance Policies**

**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 one has paid a calendar year $2,300 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,300. Out-of-pockets expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Parts A and B, but do not include the plan's separate foreign travel emergency deductible.

BENEFIT	MEDICARE PAYS
MEDICARE PART B'S PHYSICIAN SERVICES AND SUPPLIES (PER CALENDAR YEAR)	
Part B deductible $185	$0
Coinsurance	Generally 80% (after Part B deductible)
Part B – Excess Charges	$0
Blood – first 3 pints	$0
Blood – next $185 of Medicare approved amounts	$0
Blood – remainder of Medicare approved amounts	80%
Preventive benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts
ADDITIONAL BENEFITS	
Foreign Travel – Emergency care outside U.S.	$0

THP MEDICARE SUPPLEMENT INSURANCE POLICIES PAY

PLAN A	PLAN C	PLAN D	PLAN F**	PLAN G	PLAN N
$0	$185 (Part B Deductible)	$0	$185 (Part B deductible)	$0	$0
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	$0		100%		$0
First 3 pints					
$0	$185 (Part B Deductible)	$0	$185 (Part B Deductible)	$0	$0
20%					
Remainder of Medicare approved amounts					
$0	80% to a lifetime maximum benefit of $50,000 (after $250 annual deductible)				

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Guaranteed
Issue Guide

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 with an employee welfare benefit plan that provides benefits that supplement Medicare, but the plan terminated or stopped providing all such supplemental benefits; or you enrolled with 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

5

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 involuntarily because of:

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

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, 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 – OPEN ENROLLMENT PERIOD

Your guaranteed issue period begins on the earlier of the date on which you receivenotice 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.

8

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

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.

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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 Health 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 Health 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 St.
Wheeling, WV 26003
1.877.847.7907, TTY: 711 | Fax: 740.699.6163
email: 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.**

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:

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  - 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. 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) schwetzscht, 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).

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