

**THP INSURANCE COMPANY, INC. (THP)
MEDICARE SUPPLEMENT PLAN N Ohio and West Virginia**

SCHEDULE OF BENEFITS

This Schedule of Benefits pays for deductibles, coinsurance and other parts of healthcare expenses that Medicare does not pay and may provide some additional benefits. Amounts paid under this Schedule of Benefits will be changed automatically to coincide with any changes in the applicable Medicare deductible and coinsurance amounts.

The benefits listed below shall not duplicate benefits provided by Medicare. These benefits are subject to the Exclusions and Limitations Section of this Schedule of Benefits.

If you are confined to a hospital or Skilled Nursing Facility on the date coverage is terminated, the benefits of this Policy will be extended to the date you are discharged from or transferred out of such facility, at which time coverage will cease.

**Plan N
Benefits**

Medicare Part A Coinsurance Amount for Days 61-90. THP will pay for the Medicare Part A coinsurance amount for days 61-90 of a hospital stay in each Medicare benefit period. The amount of this coinsurance is set each year by Medicare. In 2019, the coinsurance amount is \$341 per day.

Medicare Part A Coinsurance Amount After the 90th Day. After the 90th day, while you use Your Medicare Lifetime Reserve Days (total of 60 per lifetime), THP will pay for the Medicare Part A coinsurance. The amount of this coinsurance is set each year by Medicare. In 2019, the coinsurance amount is \$682 per day.

After all Medicare Hospital Benefits are Exhausted, Coverage for 100% of the Medicare Part A Eligible Hospital Expenses. THP will provide coverage for 100% of the Medicare Part A eligible hospital expenses after all of Your Medicare hospital benefits have been used including Your Medicare Lifetime Reserve Days. This coverage is limited to a maximum of 365 days of additional inpatient hospital care during your lifetime. You may be responsible for payment when hospital benefits under this Policy are exhausted.

Blood Benefit. THP will provide coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood or equivalent quantities of packed red blood cells per calendar year, unless this blood is replaced.

Hospice Care. THP will provide coverage for the coinsurance amount for Part A Medicare eligible hospice care and respite care expenses.

Any questions or problems, call or write the THP Customer Service Department
1110 Main Street Wheeling, West Virginia 26003 or (877) 847-7907, TDD: 711. website: www.healthplan.org/medicare.

Our hours are 8:30 a.m. to 5:00 p.m., Monday through Friday.
To contact a Nurse on Call or the Utilization Review Staff after hours call: (800) 624-6961.

Medicare Part B Coinsurance. THP will provide coverage for the coinsurance amount for Part B medical services (generally 20% of Medicare-approved amount) or if you receive hospital outpatient department services under a prospective payment system, the copayment amount, after the \$185 annual deductible is met. Part B covers doctor bills, laboratory services, outpatient hospital services and some medical supplies.

This plan requires a copayment of up to \$20 for each office visit and a copayment of up to \$50 for each emergency room visit. The emergency room copayment will be waived if you are admitted to any hospital as an inpatient and the emergency room visit is then covered as a Part A Medicare eligible expense.

Coverage for the Medicare Part A Inpatient Hospital Deductible. THP will pay all of the Medicare Part A inpatient hospital deductible amount per benefit period. The amount of this deductible is set each year by Medicare. In 2019, the deductible is \$1,364 per benefit period.

Coverage for the Skilled Nursing Facility Coinsurance amount. THP will pay billed charges up to the skilled nursing coinsurance amount Medicare does not pay from the 21st through 100th day of Skilled Nursing Facility confinement per benefit period eligible under Medicare Part A. The confinement must meet the Medicare criteria for admission to a Skilled Nursing Facility. This Benefit does not include custodial care or treatment for substance abuse or mental disorders. In 2019, the coinsurance amount is \$170.50 per day, for days 21-100 per benefit period.

Coverage for the Medicare Part B Deductible. THP does not pay the Part B Medicare deductible per calendar year. In 2019, the Part B Medicare deductible is \$185 per calendar year.

Emergency Care in a Foreign Country. THP will pay 80% coverage for medically necessary emergency care received in a foreign country, after you pay a \$250 deductible. The emergency care must be medically necessary emergency hospital, physician or medical care received in a foreign country, which would have been Medicare eligible coverage, if the care had been received in the United States. The emergency care must have begun during the first 60 consecutive days of each trip out of the United States. Foreign emergency care is covered up to a lifetime maximum benefit of \$50,000.

Coverage for 100% of Medicare Part B Excess Charges. THP will not pay Part B excess charges above Medicare approved amounts.

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Exclusions and Limitations

1. Services not covered by Medicare (non-Medicare eligible expenses) are not covered services, unless specifically stated in this Policy.
2. Benefits shall not include duplicate payments for any procedure paid by Medicare.
3. Services furnished before the Issue/Effective Date of coverage, or after the effective date of termination, are not covered services, unless specifically stated in this Policy.

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To contact a Nurse on Call or the Utilization Review Staff after hours call: (800) 624-6961.



Discrimination is Against the Law

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Wann du Deitsch (Pennsylvania German / Dutch) schwetzsch, kantscht 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 spreek, 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).