

SERFF Tracking Number: *THRV-126359093* State: *Arkansas*
 Filing Company: *Thrivent Financial for Lutherans* State Tracking Number: *44313*
 Company Tracking Number:
 TOI: *MS09 Medicare Supplement - Other 2010* Sub-TOI: *MS09.000 Medicare Supplement Other 2010*
 Product Name: *Medicare Supplement 2010*
 Project Name/Number: */*

Filing at a Glance

Company: Thrivent Financial for Lutherans
 Product Name: Medicare Supplement 2010 SERFF Tr Num: THRV-126359093 State: Arkansas
 TOI: MS09 Medicare Supplement - Other 2010 SERFF Status: Closed-Approved- State Tr Num: 44313
 Closed
 Sub-TOI: MS09.000 Medicare Supplement Co Tr Num: State Status: Approved-Closed
 Other 2010
 Filing Type: Form/Rate Reviewer(s): Stephanie Fowler
 Disposition Date: 01/22/2010
 Authors: Julie Panaro, Matt
 Holderness
 Date Submitted: 12/10/2009 Disposition Status: Approved-
 Closed
 Implementation Date Requested: 06/01/2010 Implementation Date: 06/01/2010
 State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Not Filed
 Project Number: Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments: These forms are
 not available in the state of Wisconsin.
 Explanation for Combination/Other: Market Type: Individual
 Submission Type: New Submission Group Market Size:
 Overall Rate Impact: Group Market Type:
 Filing Status Changed: 01/22/2010 Explanation for Other Group Market Type:
 State Status Changed: 01/22/2010
 Deemer Date: Created By: Julie Panaro
 Submitted By: Julie Panaro Corresponding Filing Tracking Number:
 Filing Description:
 To comply with the Medicare Improvements for Patients and Providers Act of 2008 and corresponding NAIC model
 revisions, we are submitting for your review and approval nine Medicare Supplement contracts, a new application form,
 and two Outlines of Coverage for use with the contracts. Plans G, High Deductible F and M are new contracts that we
 have not issued before, and our current Plans H & I will no longer be available. The other contracts replace similar plans
 that we are currently issuing and are only being updated as required by the Medicare Supplement Modernization. We
 will continue to offer only one contract form for each Medicare supplement plan.

SERFF Tracking Number: *THR-126359093* State: *Arkansas*
Filing Company: *Thrivent Financial for Lutherans* State Tracking Number: *44313*
Company Tracking Number:
TOI: *MS09 Medicare Supplement - Other 2010* Sub-TOI: *MS09.000 Medicare Supplement Other 2010*
Product Name: *Medicare Supplement 2010*
Project Name/Number: */*

The new contract forms are as follows:

M-MA-MSA (10), Medicare Supplement Insurance Plan A
M-MB-MSB (10), Medicare Supplement Insurance Plan B
M-MC-MSC (10), Medicare Supplement Insurance Plan C
M-MD-MSD (10), Medicare Supplement Insurance Plan D
M-MF-MSF (10), Medicare Supplement Insurance Plan F
M-MH-MSFHI (10), Medicare Supplement Insurance High Deductible Plan F
M-MG-MSG (10), Medicare Supplement Insurance Plan G
M-ML-MSL (10), Medicare Supplement Insurance Plan L
M-MM-MSM (10), Medicare Supplement Insurance Plan M

The contract forms being replaced are listed below. They were approved by your Department on 06/08/2006.

M-EA-MSA (05) – Medicare Supplement Insurance Plan A
M-EB-MSB (05) – Medicare Supplement Insurance Plan B
M-EC-MSC (05) – Medicare Supplement Insurance Plan C
M-ED-MSD (05) – Medicare Supplement Insurance Plan D
M-EF-MSF (05) – Medicare Supplement Insurance Plan F
M-EL-MSL (05) – Medicare Supplement Insurance Plan L

Form 23798AR R1-10 Medicare Supplement Insurance Application

This application replaces application form 23798AR N9-05 that was approved by your Department on 06/08/2006. The application has been revised according to the Medicare Supplement Modernization. Therefore, the only change that has been made has been to remove the reference to plans H & I in Section 3 – New Business Product Information.

The application may be completed electronically on a laptop computer or manually on a paper copy. The application software on each representative's computer is secure and cannot be altered by the agent. Applications completed on the computer may be electronically submitted to our home office or they may be printed, signed and mailed to us. When a computer application is completed and has been reviewed by the applicant, all necessary signatures are captured electronically and transmitted as part of the application. Signatures are encrypted and cannot be transferred or used for any other purpose. If any changes are made to the application after the signature has been processed, the signature will be erased and the entire application must then be reviewed and signed again. In all cases, a printed copy of the signed application will be included in the contract at time of issue. The final printed copy of the application that will be attached to the contract is the same whether it was generated electronically or submitted on paper.

Forms 26735AR N1-10 & A26735AR N1-10 Outlines of Medicare Supplement Coverage

SERFF Tracking Number: THRV-126359093 State: Arkansas
Filing Company: Thrivent Financial for Lutherans State Tracking Number: 44313
Company Tracking Number:
TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010
Product Name: Medicare Supplement 2010
Project Name/Number: /

Filing Fees

Fee Required? Yes
Fee Amount: \$450.00
Retaliatory? No
Fee Explanation: \$50 per each contract (includes app and outlines used with the contracts)

9 contracts are included in the filing.

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Thrivent Financial for Lutherans	\$450.00	12/10/2009	32687220

SERFF Tracking Number: THRV-126359093 State: Arkansas
 Filing Company: Thrivent Financial for Lutherans State Tracking Number: 44313
 Company Tracking Number:
 TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010
 Product Name: Medicare Supplement 2010
 Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	01/22/2010	01/22/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Stephanie Fowler	01/20/2010	01/20/2010	Julie Panaro	01/21/2010	01/21/2010

SERFF Tracking Number: *THR-126359093* *State:* *Arkansas*
Filing Company: *Thrivent Financial for Lutherans* *State Tracking Number:* *44313*
Company Tracking Number:
TOI: *MS09 Medicare Supplement - Other 2010* *Sub-TOI:* *MS09.000 Medicare Supplement Other 2010*
Product Name: *Medicare Supplement 2010*
Project Name/Number: /

Disposition

Disposition Date: 01/22/2010

Implementation Date: 06/01/2010

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *THR-126359093* State: *Arkansas*
 Filing Company: *Thrivent Financial for Lutherans* State Tracking Number: *44313*
 Company Tracking Number:
 TOI: *MS09 Medicare Supplement - Other 2010* Sub-TOI: *MS09.000 Medicare Supplement Other 2010*
 Product Name: *Medicare Supplement 2010*
 Project Name/Number: */*

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification	Accepted for Informational Purposes	No
Supporting Document	Outline of Coverage		Yes
Supporting Document	Statement of Variability	Accepted for Informational Purposes	Yes
Form	Medicare Supplement Insurance Plan A	Approved	Yes
Form	Medicare Supplement Insurance Plan B	Approved	Yes
Form	Medicare Supplement Insurance Plan C	Approved	Yes
Form	Medicare Supplement Insurance Plan D	Approved	Yes
Form	Medicare Supplement Insurance Plan F	Approved	Yes
Form	Medicare Supplement Insurance High Deductible Plan F	Approved	Yes
Form	Medicare Supplement Insurance Plan G	Approved	Yes
Form	Medicare Supplement Insurance Plan L	Approved	Yes
Form	Medicare Supplement Insurance Plan M	Approved	Yes
Form	Medicare Supplement Insurance Application	Approved	Yes
Form	Outline of Medicare Supplement Coverage	Approved	Yes
Form	Outline of Medicare Supplement Coverage	Approved	Yes
Rate	Medicare Supplement Insurance Plan A	Approved	Yes
Rate	Medicare Supplement Insurance Plan B	Approved	Yes
Rate	Medicare Supplement Insurance Plan C	Approved	Yes
Rate	Medicare Supplement Insurance Plan D	Approved	Yes
Rate	Medicare Supplement Insurance Plan F	Approved	Yes
Rate	Medicare Supplement Insurance High Deductible Plan F	Approved	Yes
Rate	Medicare Supplement Insurance Plan G	Approved	Yes
Rate	Medicare Supplement Insurance Plan L	Approved	Yes
Rate	Medicare Supplement Insurance Plan M	Approved	Yes

SERFF Tracking Number: THRV-126359093 State: Arkansas
Filing Company: Thrivent Financial for Lutherans State Tracking Number: 44313
Company Tracking Number:
TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010
Product Name: Medicare Supplement 2010
Project Name/Number: /

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 01/20/2010
Submitted Date 01/20/2010
Respond By Date 02/22/2010

Dear Julie Panaro,

This will acknowledge receipt of the captioned filing.

Objection 1

- Medicare Supplement Insurance Plan A, M-MA-MSA (10) (Form)
- Medicare Supplement Insurance Plan B, M-MB-MSB (10) (Form)
- Medicare Supplement Insurance Plan C, M-MC-MSC (10) (Form)
- Medicare Supplement Insurance Plan D, M-MD-MSD (10) (Form)
- Medicare Supplement Insurance Plan F, M-MF-MSF (10) (Form)
- Medicare Supplement Insurance High Deductible Plan F, M-MH-MSFHI (10) (Form)
- Medicare Supplement Insurance Plan G, M-MG-MSG (10) (Form)
- Medicare Supplement Insurance Plan L, M-ML-MSL (10) (Form)
- Medicare Supplement Insurance Plan M, M-MM-MSM (10) (Form)

Comment: Page 8 - 7.5 MAINTENANCE OF SOLVENCY - Please remove this provision, as the only fees or charges that the insured is responsible for is their premium for their policy. They cannot be charged anything above that premium.

Please feel free to contact me if you have questions.

Sincerely,
Stephanie Fowler

Response Letter

Response Letter Status Submitted to State
Response Letter Date 01/21/2010
Submitted Date 01/21/2010

Dear Stephanie Fowler,

Comments:

Response to Objection Letter dated 01/20/2010.

SERFF Tracking Number: THRV-126359093 State: Arkansas
Filing Company: Thrivent Financial for Lutherans State Tracking Number: 44313
Company Tracking Number:
TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010
Product Name: Medicare Supplement 2010
Project Name/Number: /

Response 1

Comments: A.C.A. § 23-74-404 requires the following:

(d) A society shall provide in its laws that if its reserves as to all or any class of certificates become impaired, its board of directors or corresponding body may require that there shall be paid by the owner to the society the amount of the owner's equitable proportion of such deficiency as ascertained by its board, and that if the payment is not made, either:

(1) It shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates; or

(2) In lieu of or in combination with subdivision (d)(1) of this section, the owner may accept a proportionate reduction in benefits under the certificate. The society may specify the manner of the election and which alternative is to be presumed if no election is made.

We ask that you please reconsider your objection as this is a standard provision for Fraternal Benefit Society certificates.

Related Objection 1

Applies To:

- Medicare Supplement Insurance Plan A, M-MA-MSA (10) (Form)
- Medicare Supplement Insurance Plan B, M-MB-MSB (10) (Form)
- Medicare Supplement Insurance Plan C, M-MC-MSC (10) (Form)
- Medicare Supplement Insurance Plan D, M-MD-MSD (10) (Form)
- Medicare Supplement Insurance Plan F, M-MF-MSF (10) (Form)
- Medicare Supplement Insurance High Deductible Plan F, M-MH-MSFHI (10) (Form)
- Medicare Supplement Insurance Plan G, M-MG-MSG (10) (Form)
- Medicare Supplement Insurance Plan L, M-ML-MSL (10) (Form)
- Medicare Supplement Insurance Plan M, M-MM-MSM (10) (Form)

Comment:

Page 8 - 7.5 MAINTENANCE OF SOLVENCY - Please remove this provision, as the only fees or charges that the insured is responsible for is their premium for their policy. They cannot be charged anything above that premium.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

SERFF Tracking Number: THRV-126359093 State: Arkansas
 Filing Company: Thrivent Financial for Lutherans State Tracking Number: 44313
 Company Tracking Number:
 TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010
 Product Name: Medicare Supplement 2010
 Project Name/Number: /

Form Schedule

Lead Form Number: M-MA-MSA (10)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 01/22/2010	M-MA-MSA (10)	Policy/Cont ract/Fratern al Insurance Certificate	Medicare Supplement Plan A	Revised	Replaced Form #: M-51.700 EA-MSA (05) Previous Filing #: 32397		AR Med Supp Contract M-MA-MSA (10).pdf
Approved 01/22/2010	M-MB-MSB (10)	Policy/Cont ract/Fratern al Insurance Certificate	Medicare Supplement Plan B	Revised	Replaced Form #: M-51.600 EB-MSB (05) Previous Filing #: 32397		AR Med Supp Contract M-MB-MSB (10).pdf
Approved 01/22/2010	M-MC-MSC (10)	Policy/Cont ract/Fratern al Insurance Certificate	Medicare Supplement Plan C	Revised	Replaced Form #: M-50.900 EC-MSB (05) Previous Filing #: 32397		AR Med Supp Contract M-MC-MSB (10).pdf
Approved 01/22/2010	M-MD-MSD (10)	Policy/Cont ract/Fratern al Insurance Certificate	Medicare Supplement Plan D	Revised	Replaced Form #: M-51.000 ED-MSD (05) Previous Filing #: 32397		AR Med Supp Contract M-MD-MSD (10).pdf
Approved 01/22/2010	M-MF-MSF (10)	Policy/Cont ract/Fratern al Insurance Certificate	Medicare Supplement Plan F	Revised	Replaced Form #: M-51.100 EF-MSF (05) Previous Filing #: 32397		AR Med Supp Contract M-MF-MSF (10).pdf
Approved 01/22/2010	M-MH-MSFHI (10)	Policy/Cont ract/Fratern al Insurance Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Medicare High Deductible Plan F	Initial		51.000	AR Med Supp Contract M-MH-MSFHI (10).pdf
Approved	M-MG-	Policy/Cont	Medicare	Initial		51.200	AR Med Supp

<i>SERFF Tracking Number:</i>	<i>THR-126359093</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Thrivent Financial for Lutherans</i>	<i>State Tracking Number:</i>	<i>44313</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>MS09 Medicare Supplement - Other 2010</i>	<i>Sub-TOI:</i>	<i>MS09.000 Medicare Supplement Other 2010</i>
<i>Product Name:</i>	<i>Medicare Supplement 2010</i>		
<i>Project Name/Number:</i>	/		
01/22/2010 MSG (10)	ract/Fratern Supplement al Insurance Plan G Certificate		Contract M- MG-MSG (10).pdf
Approved M-ML-MSL 01/22/2010 (10)	Policy/Cont Medicare ract/Fratern Supplement al Insurance Plan L Certificate	Revised	Replaced Form #: M- 51.400 EL-MSL (05) Previous Filing #: 32397
Approved M-MM- 01/22/2010 MSM (10)	Policy/Cont Medicare ract/Fratern Supplement al Insurance Plan M Certificate	Initial	51.000 AR Med Supp Contract M- MM-MSM (10).pdf
Approved 23798AR 01/22/2010 R1-10	Application/Medicare Enrollment Supplement Form Insurance Application	Revised	Replaced Form #: 54.500 23798AR N9-05 Previous Filing #: 32397 Medicare Supplement Insurance Application 23798AR R1- 10.pdf
Approved 26735AR 01/22/2010 N1-10	Outline of Coverage	Outline of Medicare Supplement Coverage	Revised Replaced Form #: 0.000 23817AR N1-06 Previous Filing #: 32397 AR Outline of Coverage 26735AR N1- 10.pdf
Approved A26735AR 01/22/2010 N1-10	Outline of Coverage	Outline of Medicare Supplement Coverage	Revised Replaced Form #: 0.000 A23817AR N1-06 Previous Filing #: 32397 AR Outline of Coverage A26735AR N1-10.pdf

This certificate of membership and Medicare supplement insurance is a legal contract between you and Thrivent Financial for Lutherans. We issue this contract based on the signed Application and payment of the Initial Premium shown on page 3. We will pay benefits according to the provisions of this contract. Coverage begins at 12:01 a.m. on the Date of Issue or, if later, the date we receive the Initial Premium for this contract. It ends at 11:59 p.m. on the day this contract terminates (see Section 7.11).

This contract is guaranteed renewable for life. You may keep this contract in force, regardless of any change in health, by paying premiums when due. We cannot cancel this contract or reduce benefits other than as provided in Section 4.

Table of Premiums - Premiums May Change. The Initial Premium is shown on page 3. It applies to the first year of coverage. Renewal premiums will be charged according to our table of premiums in effect on each Contract Anniversary. We expect premiums to increase as Medicare benefits change and as health care costs increase. Premiums also depend on your place of residence. Any change in premiums will apply on a class basis to all contracts in force on this form in your state of residence. We will not change your premium due to changes in your health or due to any claims on this contract.

Notice to Buyer: This contract may not cover all of your medical expenses.

Right to Cancel. Please read this contract carefully. You may cancel the contract for any reason before midnight of the 30th day after you first receive it. Do this by (1) mailing or delivering Written Notice to our Service Center and (2) returning the contract. Notice given by mail and return of the contract by mail are effective on being postmarked, properly addressed and postage prepaid. If you cancel the contract, it will be deemed void from the beginning and we will refund any premium paid.

Important Notice - Statements in the Application. Please read the copy of the Application attached to this contract. This contract was issued on the basis that all information shown in the Application is correct and complete. Omissions or misstatements in the application could cause a claim to be denied or make this contract void. If any information shown is not correct or complete or if any past medical history has been left out of the Application, contact us immediately.

Caution: This contract covers only those expenses that are approved for payment by Medicare.

Medicare supplement insurance.
Guaranteed renewable for life.
Premiums expected to increase.

Signed for the Society

President []

Secretary []

INSURED: [JOHN DOE]

AGE: [65] SEX: [MALE]

CONTRACT NUMBER: [H0012345]

DATE OF ISSUE: [JUNE 1, 2010]

Table of Contents

Cover Page
Index
Contract Schedule, Contract Data
Section 1 Definitions
Section 2 Benefits
Section 3 Exclusions
Section 4 Adjustments to Benefits
Section 5 Claims
Section 6 Premiums and Reinstatement
Section 7 General Provisions
Amendments, Endorsements, Application

Index

	Section		Section
Adjustments to Benefits	4	Payment of Claims	5
Basic Benefits	2	Physical Examinations	5
Benefit Appeals Procedure	5	Premium in Default and Grace Period	6
Change of Contract	7	Premium Payments	6
Changes in Medicare	4	Proof of Loss	5
Changes in Premium	6	Reimbursement and Subrogation	5
Claim Forms	5	Reinstatement	6
Entire Contract	7	Statements in the Application	7
Exclusions	3	Suspension of Benefits and Premiums	7
Legal Proceedings	5	Termination	7
Maintenance of Solvency	7	Time Limit on Certain Defenses	7
Membership	7	Time of Payment of Claims	5
Notice of Claim	5		

Contract Schedule

Telephone [(800) 847-4836]

	ANNUAL PREMIUM#
BASIC BENEFIT MEDICARE SUPPLEMENT INSURANCE - PLAN A	[\$X,XXX.00]
RISK CLASS: [STANDARD NON-TOBACCO]	
TOTAL ANNUAL PREMIUM	[\$X,XXX.00]
INTERVAL OF PAYMENT	[ANNUAL]
INITIAL PREMIUM	[\$X,XXX.00]

PREMIUMS ARE SUBJECT TO CHANGE ON EACH CONTRACT ANNIVERSARY. WE EXPECT PREMIUMS TO INCREASE AS MEDICARE BENEFITS CHANGE AND AS HEALTH CARE COSTS INCREASE. PREMIUMS DEPEND ON YOUR PLACE OF RESIDENCE.

INSURED: [JOHN DOE]

AGE: [65] SEX: [MALE]

CONTRACT NUMBER: [H0012345]

DATE OF ISSUE: [JUNE 1, 2010]

1. DEFINITIONS

Application. The application(s) and all application supplements and amendments to the Application.

Calendar Year. The period beginning on each January 1 and ending the following December 31.

Coinsurance. The percentage of Medicare Eligible Expenses you must pay after Medicare payments begin. Coinsurance does not include any Deductibles. Coinsurance percentages are set by Medicare.

Copayment. The fixed amount of Medicare Eligible Expenses you must pay after Medicare payments begin. Copayment amounts do not include any Deductibles. Copayment amounts are set each year by Medicare.

Contract Anniversary. The same month and day for years after issue as in the Date of Issue on page 3.

Deductible. A fixed amount of Medicare Eligible Expenses that is not paid by Medicare. The Part A Deductible applies to the first 60 days of Hospital confinement in each Medicare Benefit Period. The Part B Deductible applies to each Calendar Year. Deductible amounts are set each year by Medicare.

Doctor. A legally qualified and licensed practitioner of the healing arts who is practicing within the scope of his authority.

Explanation of Medicare Benefits Form. The statement supplied to you by Medicare that shows the action taken on your Medicare claim.

Hospital. A legally operated facility that is approved or is eligible to be approved for payment of Medicare benefits for hospitalization, and that:

- 1) Is accredited as a hospital by the Joint Commission on Accreditation of Hospitals; or
- 2) Provides
 - a) Either on its premises or in facilities available on a prearranged basis, medical, diagnostic and major surgical facilities under the supervision of a staff of one or more Doctors for the care and treatment of sick or injured patients on an inpatient basis; and
 - b) 24-hour nursing service.

Injury. Accidental bodily injury sustained while this contract is in force.

Issue Age. Your age on the Date of Issue of this contract.

Medicaid. The Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

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

Medicare Benefit Period. The period as determined by Medicare that begins the day you are admitted to a Hospital. It ends when you have been in neither a Hospital nor a Skilled Nursing Facility for at least 60 consecutive days.

Medicare Eligible Expenses. Expenses approved by Medicare as eligible for payment under Medicare.

Medicare Lifetime Reserve Days. Extra days of Hospital coverage provided under Medicare Part A and Part B. You may use this coverage after the first 90 days of Hospital coverage during a Medicare Benefit Period.

Medicare Part A. Part A of Medicare, also known as Medicare Hospital Insurance.

Medicare Part B. Part B of Medicare, also known as Medicare Supplementary Medical Insurance.

Service Center. The location where this contract is administered. The Service Center address is shown on page 3.

Sickness. Illness or disease that first manifests itself while the contract is in force.

Skilled Nursing Facility. A legally operated facility or that part of one that is approved or eligible to be approved for payment of Medicare benefits for skilled nursing facility care.

we, our, us, Society. Thrivent Financial for Lutherans.

Written Notice. A written request or notice signed by you and received in good order by us at our Service Center.

you, your, yours. The insured.

2. BENEFITS

CORE BENEFITS

2.1 BASIC BENEFITS. For Medicare Eligible Expenses you incur for treatment of Sickness or Injury, we will pay:

- 1) Medicare Part A expenses for hospitalization that are not covered by Medicare from the 61st day through the 90th day of confinement in a Medicare Benefit Period.
- 2) Medicare Part A expenses for hospitalization that are not covered by Medicare for each day that you use one of your Medicare Lifetime Reserve days.
- 3) If you are confined for more than 90 days and you have used all of your Medicare Lifetime Reserve Days, all Medicare Part A expenses for hospitalization, subject to a lifetime maximum benefit of an additional 365 days.

Benefits will be paid at the applicable prospective payment system rate or other appropriate Medicare standard of payment.

- 4) Medicare Part A expenses for hospice and respite care that are not covered by Medicare.
- 5) Expenses for the first 3 pints of blood you receive under Medicare Parts A and B (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.
- 6) The Coinsurance portion of Medicare Part B expenses in any Calendar Year in excess of the Part B Deductible amount. For Hospital outpatient expenses paid under a prospective payment system, we will pay the Copayment amount.

3. EXCLUSIONS

3.1 EXCLUSIONS. This contract covers only those expenses that are approved for payment by Medicare.

This contract does not cover expenses due to:

- 1) Care, treatment or supplies to the extent that you are entitled to have payment made under:
 - a) Medicare or any other governmental program (except Medicaid);

b) Any other Medicare Supplement Insurance contract; or

c) Any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law;

- 2) Services for which no charge is normally made in the absence of insurance; or
- 3) Items or services for which you have no legal obligation to pay.

4. ADJUSTMENTS TO BENEFITS

4.1 ADJUSTMENTS TO BENEFITS. At the beginning of each Calendar Year, we will adjust your benefits to reflect any changes in the Part A Deductible, Copayment amounts or the Part B Deductible. If an adjustment results in a change in premium, the new premium will be effective on the first Contract Anniversary after the adjustment in benefits. We will give you at least 30 days notice of any increase in premium.

4.2 CHANGES IN MEDICARE. Changes in Medicare, other than as in Section 4.1, that affect the coverage provided by this contract may require an adjustment in benefits and premiums.

5. CLAIMS

5.1 NOTICE OF CLAIM. A notice of claim must be given to us at our Service Center within 30 days after a covered loss starts or as soon after this as reasonably possible. Notice should include your name and contract number.

5.2 CLAIM FORMS. When we receive your notice of claim, we will send you information for filing proof of loss. If we do not send this information within 15 days, you may meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in Section 5.3.

5.3 PROOF OF LOSS. Proof of loss must be given to us at our Service Center. This should be done within 90 days after the loss occurs. Failure to give proof within 90 days will not affect the claim if proof is given as soon as is reasonably possible, but the proof must be given no later than one year from the time proof is otherwise required, unless you were legally incapacitated.

Before filing a claim for Part B Medicare Eligible Expenses under this contract, you must first file your claim with Medicare. Send us the Explanation of Medicare Benefits form that you receive from Medicare and the itemized bills from your health care providers. On dually assigned claims submitted by participating Doctors and suppliers, we will accept notice from the Medicare carriers as a claim for benefits in place of any other claim form otherwise required and we will make a payment determination based on the information contained in that notice.

5.4 TIME OF PAYMENT OF CLAIMS. We will pay benefits for losses covered under this contract as soon as we receive sufficient proof of loss.

5.5 PAYMENT OF CLAIMS. Benefits will be paid to you or to your health care provider to whom you have assigned benefits. Any benefits payable to you that are unpaid at your death will be paid to your estate.

5.6 PHYSICAL EXAMINATIONS. In addition to other proof of loss, we may require you to have physical examinations as often as reasonably necessary while a claim is pending or being paid. It will be at our expense.

5.7 BENEFIT APPEALS PROCEDURE. If you have a claim for benefits that is denied in whole or in part, you may appeal the claim denial by sending us a written request for review. Mail this request to our Service Center and enclose any information that you think will help us review your claim. Within 30 days after we receive your request, we will review your claim in detail and send you written notification of the results of the review.

5.8 LEGAL PROCEEDINGS. No legal proceeding to recover on this contract may be commenced until at least 60 days after written proof of loss has been given. No such proceeding may be commenced after 3 years from the time written proof of loss is required to be given.

5. CLAIMS

(continued)

5.9 REIMBURSEMENT AND SUBROGATION. If we pay any benefits for any expenses you incur due to any act of a third party who is or may become liable to you because of that act, then we are entitled to subrogation from the third party. If you recover from a third party, the reasonable costs of collection and attorney fees will be assessed against you and us in the proportion that each benefits from recovery.

You must provide us with timely written notice of any claim you make against a third party for payment or reimbursement of medical and medically-related expenses. At our option, we may take any action we deem appropriate to protect our rights under this reimbursement and subrogation provision including, without limitation, seeking to intervene in any lawsuit or other proceeding you have begun against a third party. The statute of limitations applicable to our right to seek reimbursement or subrogation does not begin to run until you have given us written notice.

6. PREMIUMS AND REINSTATEMENT

6.1 PREMIUM PAYMENTS. The Initial Premium amount and its Interval of Payment are shown on page 3. The Initial Premium is due and payable on the Date of Issue. Each subsequent premium is due on the first day of its Interval of Payment.

Premiums are payable at our Service Center. Upon request, we will give you a receipt, signed by an officer of the Society, for premium paid.

6.2 PREMIUM BILLING. We will send premium billings based upon the Interval of Payment that you request. Subject to our published rules, you may change the Interval of Payment or the method of billing by giving Written Notice.

6.3 CHANGES IN PREMIUM. We may change our table of premiums on any Contract Anniversary. Any change will apply to all like contracts in force in your state of residence. We will not change your premium because of a change in your health. If your premium changes because of a change in your place of residence, the new premium will be effective on the next premium due date after your change of residence. We will give you at least 30 days notice of any increase in premium.

6.4 PREMIUM IN DEFAULT AND GRACE PERIOD. Any premium not paid on or before the date it is due is a premium in default. Except for the Initial Premium, you may pay the premium in default within a grace period of 31 days after the date it is due. During the grace period, this contract will remain in force. If the premium in default is not paid within the grace period, this contract will terminate at the end of the grace period.

6.5 REINSTATEMENT. If this contract terminates as in Section 6.4, you must pay any premium in default to reinstate it. The contract is reinstated when we accept the payment, unless we also require an application for reinstatement.

If we require an application for reinstatement, we must give you notice of approval or disapproval within 45 days after the date of the application. We will reinstate the contract as soon as it is approved. If we do not notify you within this 45-day period, the contract will automatically be reinstated on the 45th day.

The reinstated contract will cover only losses that result from:

- 1) Injury sustained after the date of reinstatement; or
- 2) Sickness that first manifests itself after the date of reinstatement.

All other rights that you or we had immediately before the default in premium payments again apply, subject to any provisions endorsed on or attached to this contract when it is reinstated.

Section 7.4 Time Limit on Certain Defenses will apply from the date the contract is reinstated with regard to statements made in the application for reinstatement.

This contract cannot be reinstated after 5 months from the end of the grace period.

7. GENERAL PROVISIONS

7.1 ENTIRE CONTRACT. The Entire Contract consists of:

- 1) This contract including any attached riders, amendments or endorsements;
- 2) The Application attached to this contract; and
- 3) The Articles of Incorporation and Bylaws of the Society and all amendments to them.

Benefits will not be reduced by any future amendments to our Articles of Incorporation or Bylaws.

7.2 CHANGE OF CONTRACT. No change to this contract is valid unless it is made in writing and signed by our President or Secretary.

7.3 STATEMENTS IN THE APPLICATION. We will not use any statements to contest a claim or to have this contract declared invalid unless the statement is contained in the Application. All statements made in the Application are considered representations, not warranties.

7.4 TIME LIMIT ON CERTAIN DEFENSES.

- 1) **Misstatements in the Application.** After this contract has been in force during your lifetime for two years from the Date of Issue, no statement made in the Application, except fraudulent misrepresentation, shall be used to void this contract or deny a claim for loss incurred or disability that begins after the end of the two-year period.
- 2) **Pre-Existing Conditions.** No claim for loss incurred after the Date of Issue will be reduced or denied because a disease or physical condition existed before the Date of Issue.

This provision will apply from the date this contract is reinstated with regard to statements made in the application for reinstatement.

7.5 MAINTENANCE OF SOLVENCY. If the solvency of the Society becomes impaired, you may be required to make an extra payment. The Board of Directors will determine the amount of any extra payment. It will be based on each member's fair share of the deficiency.

7.6 MEMBERSHIP. You are a member of the Society. Rights and privileges of membership are set forth in the Articles of Incorporation and Bylaws of the Society. These rights and privileges are separate from ownership of this contract.

7.7 CONFORMITY WITH STATE STATUTES. On the Date of Issue, any provision of this contract in conflict with the laws of the state in which you reside on that date is amended to conform with those state laws.

7. GENERAL PROVISIONS

(continued)

7.8 SUSPENSION OF BENEFITS AND PREMIUMS.

- 1) **Suspension for Medicaid Eligibility.** If you are determined to be entitled to Medicaid, you may request to have this contract suspended for 24 months or, if earlier, until your entitlement to Medicaid ends. To suspend this contract, you must give us Written Notice within 90 days after entitlement for Medicaid begins.

If your entitlement ends and you give us Written Notice of that within 90 days after entitlement ends, we will reinstate your contract as of the date your entitlement ended. You must pay any premium due from the date entitlement ended. The reinstated contract will be the same as if no suspension had occurred.

- 2) **Suspension for Coverage under Social Security Act Section 226(b).** If you are disabled before age 65, entitled to disability benefits under Section 226(b) of the Social Security Act and covered under a group health plan as defined in the Social Security Act, you may request to have this contract suspended by giving us Written Notice.

If your coverage under the group health plan is terminated after this contract is suspended and you give us Written Notice of that within 90 days after termination, we will reinstate your contract as of the date of termination. You must pay any premium due from the date of termination of the group health coverage. The reinstated contract will be the same as if no suspension had occurred.

7.9 DIVIDENDS. Each year we will determine our divisible surplus. This contract's share, if any, will be credited as a dividend on the Contract Anniversary and paid to you in cash. Since we do not expect this contract to contribute to divisible surplus, it is not expected that any dividends will be credited.

7.10 TERMINATION. This contract will terminate at the earliest of the following dates:

- 1) The end of the grace period if any premium is then in default (see Section 6.4).
- 2) The date of your Written Notice to cancel this contract. The date of Written Notice is the date we receive it or, if later, the date you specify.
- 3) The date of death of the insured.

If this contract terminates, benefits for continuous losses that began while the contract was in force will continue while you are continuously totally disabled, as defined by the Social Security Act, but not beyond the end of the Medicare Benefit Period or the Calendar Year for which benefits would otherwise be payable under this contract. We will refund the portion of any premium paid for the period beyond the date of termination.

Medicare supplement insurance.
Guaranteed renewable for life.
Premiums expected to increase.



This certificate of membership and Medicare supplement insurance is a legal contract between you and Thrivent Financial for Lutherans. We issue this contract based on the signed Application and payment of the Initial Premium shown on page 3. We will pay benefits according to the provisions of this contract. Coverage begins at 12:01 a.m. on the Date of Issue or, if later, the date we receive the Initial Premium for this contract. It ends at 11:59 p.m. on the day this contract terminates (see Section 7.11).

This contract is guaranteed renewable for life. You may keep this contract in force, regardless of any change in health, by paying premiums when due. We cannot cancel this contract or reduce benefits other than as provided in Section 4.

Table of Premiums - Premiums May Change. The Initial Premium is shown on page 3. It applies to the first year of coverage. Renewal premiums will be charged according to our table of premiums in effect on each Contract Anniversary. We expect premiums to increase as Medicare benefits change and as health care costs increase. Premiums also depend on your place of residence. Any change in premiums will apply on a class basis to all contracts in force on this form in your state of residence. We will not change your premium due to changes in your health or due to any claims on this contract.

Notice to Buyer: This contract may not cover all of your medical expenses.

Right to Cancel. Please read this contract carefully. You may cancel the contract for any reason before midnight of the 30th day after you first receive it. Do this by (1) mailing or delivering Written Notice to our Service Center and (2) returning the contract. Notice given by mail and return of the contract by mail are effective on being postmarked, properly addressed and postage prepaid. If you cancel the contract, it will be deemed void from the beginning and we will refund any premium paid.

Important Notice - Statements in the Application. Please read the copy of the Application attached to this contract. This contract was issued on the basis that all information shown in the Application is correct and complete. Omissions or misstatements in the application could cause a claim to be denied or make this contract void. If any information shown is not correct or complete or if any past medical history has been left out of the Application, contact us immediately.

Caution: This contract covers only those expenses that are approved for payment by Medicare.

Medicare supplement insurance.
Guaranteed renewable for life.
Premiums expected to increase.

Signed for the Society

President []

Secretary []

INSURED: [JOHN DOE]

AGE: [65] SEX: [MALE]

CONTRACT NUMBER: [H0012345]

DATE OF ISSUE: [JUNE 1, 2010]

Table of Contents

Cover Page
Index
Contract Schedule, Contract Data
Section 1 Definitions
Section 2 Benefits
Section 3 Exclusions
Section 4 Adjustments to Benefits
Section 5 Claims
Section 6 Premiums and Reinstatement
Section 7 General Provisions
Amendments, Endorsements, Application

Index

	Section		Section
Adjustments to Benefits	4	Part A Deductible Benefit	2
Basic Benefits	2	Payment of Claims	5
Benefit Appeals Procedure	5	Physical Examinations	5
Change of Contract	7	Premium in Default and Grace Period	6
Changes in Medicare	4	Premium Payments	6
Changes in Premium	6	Proof of Loss	5
Claim Forms	5	Reimbursement and Subrogation	5
Entire Contract	7	Reinstatement	6
Exclusions	3	Statements in the Application	7
Legal Proceedings	5	Suspension of Benefits and Premiums	7
Maintenance of Solvency	7	Termination	7
Membership	7	Time Limit on Certain Defenses	7
Notice of Claim	5	Time of Payment of Claims	5

Contract Schedule

Telephone [(800) 847-4836]

	ANNUAL PREMIUM#
BASIC BENEFIT MEDICARE SUPPLEMENT INSURANCE - PLAN B	[\$X,XXX.00]
RISK CLASS: [STANDARD NON-TOBACCO]	
TOTAL ANNUAL PREMIUM	[\$X,XXX.00]
INTERVAL OF PAYMENT	[ANNUAL]
INITIAL PREMIUM	[\$X,XXX.00]

PREMIUMS ARE SUBJECT TO CHANGE ON EACH CONTRACT ANNIVERSARY. WE EXPECT PREMIUMS TO INCREASE AS MEDICARE BENEFITS CHANGE AND AS HEALTH CARE COSTS INCREASE. PREMIUMS DEPEND ON YOUR PLACE OF RESIDENCE.

INSURED: [JOHN DOE]

AGE: [65] SEX: [MALE]

CONTRACT NUMBER: [H0012345]

DATE OF ISSUE: [JUNE 1, 2010]

1. DEFINITIONS

Application. The application(s) and all application supplements and amendments to the Application.

Calendar Year. The period beginning on each January 1 and ending the following December 31.

Coinsurance. The percentage of Medicare Eligible Expenses you must pay after Medicare payments begin. Coinsurance does not include any Deductibles. Coinsurance percentages are set by Medicare.

Copayment. The fixed amount of Medicare Eligible Expenses you must pay after Medicare payments begin. Copayment amounts do not include any Deductibles. Copayment amounts are set each year by Medicare.

Contract Anniversary. The same month and day for years after issue as in the Date of Issue on page 3.

Deductible. A fixed amount of Medicare Eligible Expenses that is not paid by Medicare. The Part A Deductible applies to the first 60 days of Hospital confinement in each Medicare Benefit Period. The Part B Deductible applies to each Calendar Year. Deductible amounts are set each year by Medicare.

Doctor. A legally qualified and licensed practitioner of the healing arts who is practicing within the scope of his authority.

Explanation of Medicare Benefits Form. The statement supplied to you by Medicare that shows the action taken on your Medicare claim.

Hospital. A legally operated facility that is approved or is eligible to be approved for payment of Medicare benefits for hospitalization, and that:

- 1) Is accredited as a hospital by the Joint Commission on Accreditation of Hospitals; or
- 2) Provides
 - a) Either on its premises or in facilities available on a prearranged basis, medical, diagnostic and major surgical facilities under the supervision of a staff of one or more Doctors for the care and treatment of sick or injured patients on an inpatient basis; and
 - b) 24-hour nursing service.

Injury. Accidental bodily injury sustained while this contract is in force.

Issue Age. Your age on the Date of Issue of this contract.

Medicaid. The Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

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

Medicare Benefit Period. The period as determined by Medicare that begins the day you are admitted to a Hospital. It ends when you have been in neither a Hospital nor a Skilled Nursing Facility for at least 60 consecutive days.

Medicare Eligible Expenses. Expenses approved by Medicare as eligible for payment under Medicare.

Medicare Lifetime Reserve Days. Extra days of Hospital coverage provided under Medicare Part A and Part B. You may use this coverage after the first 90 days of Hospital coverage during a Medicare Benefit Period.

Medicare Part A. Part A of Medicare, also known as Medicare Hospital Insurance.

Medicare Part B. Part B of Medicare, also known as Medicare Supplementary Medical Insurance.

Service Center. The location where this contract is administered. The Service Center address is shown on page 3.

Sickness. Illness or disease that first manifests itself while the contract is in force.

Skilled Nursing Facility. A legally operated facility or that part of one that is approved or eligible to be approved for payment of Medicare benefits for skilled nursing facility care.

we, our, us, Society. Thrivent Financial for Lutherans.

Written Notice. A written request or notice signed by you and received in good order by us at our Service Center.

you, your, yours. The insured.

2. BENEFITS

CORE BENEFITS

2.1 BASIC BENEFITS. For Medicare Eligible Expenses you incur for treatment of Sickness or Injury, we will pay:

- 1) Medicare Part A expenses for hospitalization that are not covered by Medicare from the 61st day through the 90th day of confinement in a Medicare Benefit Period.
- 2) Medicare Part A expenses for hospitalization that are not covered by Medicare for each day that you use one of your Medicare Lifetime Reserve days.
- 3) If you are confined for more than 90 days and you have used all of your Medicare Lifetime Reserve Days, all Medicare Part A expenses for hospitalization, subject to a lifetime maximum benefit of an additional 365 days. Benefits will be paid at the applicable prospective payment system rate or other appropriate Medicare standard of payment.

- 4) Medicare Part A expenses for hospice and respite care that are not covered by Medicare.
- 5) Expenses for the first 3 pints of blood you receive under Medicare Parts A and B (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.
- 6) The Coinsurance portion of Medicare Part B expenses in any Calendar Year in excess of the Part B Deductible amount. For Hospital outpatient expenses paid under a prospective payment system, we will pay the Copayment amount.

ADDITIONAL BENEFITS

2.2 PART A DEDUCTIBLE BENEFIT. For each Medicare Benefit Period that you are confined in a Hospital as a result of Sickness or Injury, we will pay the Part A Deductible amount or, if less, the amount of Medicare Part A expenses that you incur.

3. EXCLUSIONS

3.1 EXCLUSIONS. This contract covers only those expenses that are approved for payment by Medicare.

This contract does not cover expenses due to:

- 1) Care, treatment or supplies to the extent that you are entitled to have payment made under:
 - a) Medicare or any other governmental program (except Medicaid);
 - b) Any other Medicare Supplement Insurance contract; or
 - c) Any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law;
- 2) Services for which no charge is normally made in the absence of insurance; or
- 3) Items or services for which you have no legal obligation to pay.

4. ADJUSTMENTS TO BENEFITS

4.1 ADJUSTMENTS TO BENEFITS. At the beginning of each Calendar Year, we will adjust your benefits to reflect any changes in the Part A Deductible, Copayment amounts or the Part B Deductible. If an adjustment results in a change in premium, the new premium will be effective on the first Contract Anniversary after the adjustment in benefits. We will give you at least 30 days notice of any increase in premium.

4.2 CHANGES IN MEDICARE. Changes in Medicare, other than as in Section 4.1, that affect the coverage provided by this contract may require an adjustment in benefits and premiums.

5. CLAIMS

5.1 NOTICE OF CLAIM. A notice of claim must be given to us at our Service Center within 30 days after a covered loss starts or as soon after this as reasonably possible. Notice should include your name and contract number.

5.2 CLAIM FORMS. When we receive your notice of claim, we will send you information for filing proof of loss. If we do not send this information within 15 days, you may meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in Section 5.3.

5.3 PROOF OF LOSS. Proof of loss must be given to us at our Service Center. This should be done within 90 days after the loss occurs. Failure to give proof within 90 days will not affect the claim if proof is given as soon as is reasonably possible, but the proof must be given no later than one year from the time proof is otherwise required, unless you were legally incapacitated.

Before filing a claim for Part B Medicare Eligible Expenses under this contract, you must first file your claim with Medicare. Send us the Explanation of Medicare Benefits form that you receive from Medicare and the itemized bills from your health care providers. On dually assigned claims submitted by participating Doctors and suppliers, we will accept notice from the Medicare carriers as a claim for benefits in place of any other claim form otherwise required and we will make a payment determination based on the information contained in that notice.

5.4 TIME OF PAYMENT OF CLAIMS. We will pay benefits for losses covered under this contract as soon as we receive sufficient proof of loss.

5.5 PAYMENT OF CLAIMS. Benefits will be paid to you or to your health care provider to whom you have assigned benefits. Any benefits payable to you that are unpaid at your death will be paid to your estate.

5.6 PHYSICAL EXAMINATIONS. In addition to other proof of loss, we may require you to have physical examinations as often as reasonably necessary while a claim is pending or being paid. It will be at our expense.

5.7 BENEFIT APPEALS PROCEDURE. If you have a claim for benefits that is denied in whole or in part, you may appeal the claim denial by sending us a written request for review. Mail this request to our Service Center and enclose any information that you think will help us review your claim. Within 30 days after we receive your request, we will review your claim in detail and send you written notification of the results of the review.

5.8 LEGAL PROCEEDINGS. No legal proceeding to recover on this contract may be commenced until at least 60 days after written proof of loss has been given. No such proceeding may be commenced after 3 years from the time written proof of loss is required to be given.

5. CLAIMS

(continued)

5.9 REIMBURSEMENT AND SUBROGATION. If we pay any benefits for any expenses you incur due to any act of a third party who is or may become liable to you because of that act, then we are entitled to subrogation from the third party. If you recover from a third party, the reasonable costs of collection and attorney fees will be assessed against you and us in the proportion that each benefits from recovery.

You must provide us with timely written notice of any claim you make against a third party for payment or reimbursement of medical and medically-related expenses. At our option, we may take any action we deem appropriate to protect our rights under this reimbursement and subrogation provision including, without limitation, seeking to intervene in any lawsuit or other proceeding you have begun against a third party. The statute of limitations applicable to our right to seek reimbursement or subrogation does not begin to run until you have given us written notice.

6. PREMIUMS AND REINSTATEMENT

6.1 PREMIUM PAYMENTS. The Initial Premium amount and its Interval of Payment are shown on page 3. The Initial Premium is due and payable on the Date of Issue. Each subsequent premium is due on the first day of its Interval of Payment.

Premiums are payable at our Service Center. Upon request, we will give you a receipt, signed by an officer of the Society, for premium paid.

6.2 PREMIUM BILLING. We will send premium billings based upon the Interval of Payment that you request. Subject to our published rules, you may change the Interval of Payment or the method of billing by giving Written Notice.

6.3 CHANGES IN PREMIUM. We may change our table of premiums on any Contract Anniversary. Any change will apply to all like contracts in force in your state of residence. We will not change your premium because of a change in your health. If your premium changes because of a change in your place of residence, the new premium will be effective on the next premium due date after your change of residence. We will give you at least 30 days notice of any increase in premium.

6.4 PREMIUM IN DEFAULT AND GRACE PERIOD. Any premium not paid on or before the date it is due is a premium in default. Except for the Initial Premium, you may pay the premium in default within a grace period of 31 days after the date it is due. During the grace period, this contract will remain in force. If the premium in default is not paid within the grace period, this contract will terminate at the end of the grace period.

6.5 REINSTATEMENT. If this contract terminates as in Section 6.4, you must pay any premium in default to reinstate it. The contract is reinstated when we accept the payment, unless we also require an application for reinstatement.

If we require an application for reinstatement, we must give you notice of approval or disapproval within 45 days after the date of the application. We will reinstate the contract as soon as it is approved. If we do not notify you within this 45-day period, the contract will automatically be reinstated on the 45th day.

The reinstated contract will cover only losses that result from:

- 1) Injury sustained after the date of reinstatement; or
- 2) Sickness that first manifests itself after the date of reinstatement.

All other rights that you or we had immediately before the default in premium payments again apply, subject to any provisions endorsed on or attached to this contract when it is reinstated.

Section 7.4 Time Limit on Certain Defenses will apply from the date the contract is reinstated with regard to statements made in the application for reinstatement.

This contract cannot be reinstated after 5 months from the end of the grace period.

7. GENERAL PROVISIONS

7.1 ENTIRE CONTRACT. The Entire Contract consists of:

- 1) This contract including any attached riders, amendments or endorsements;
- 2) The Application attached to this contract; and
- 3) The Articles of Incorporation and Bylaws of the Society and all amendments to them.

Benefits will not be reduced by any future amendments to our Articles of Incorporation or Bylaws.

7.2 CHANGE OF CONTRACT. No change to this contract is valid unless it is made in writing and signed by our President or Secretary.

7.3 STATEMENTS IN THE APPLICATION. We will not use any statements to contest a claim or to have this contract declared invalid unless the statement is contained in the Application. All statements made in the Application are considered representations, not warranties.

7.4 TIME LIMIT ON CERTAIN DEFENSES.

- 1) **Misstatements in the Application.** After this contract has been in force during your lifetime for two years from the Date of Issue, no statement made in the Application, except fraudulent misrepresentation, shall be used to void this contract or deny a claim for loss incurred or disability that begins after the end of the two-year period.
- 2) **Pre-Existing Conditions.** No claim for loss incurred after the Date of Issue will be reduced or denied because a disease or physical condition existed before the Date of Issue.

This provision will apply from the date this contract is reinstated with regard to statements made in the application for reinstatement.

7.5 MAINTENANCE OF SOLVENCY. If the solvency of the Society becomes impaired, you may be required to make an extra payment. The Board of Directors will determine the amount of any extra payment. It will be based on each member's fair share of the deficiency.

7.6 MEMBERSHIP. You are a member of the Society. Rights and privileges of membership are set forth in the Articles of Incorporation and Bylaws of the Society. These rights and privileges are separate from ownership of this contract.

7.7 CONFORMITY WITH STATE STATUTES. On the Date of Issue, any provision of this contract in conflict with the laws of the state in which you reside on that date is amended to conform with those state laws.

7. GENERAL PROVISIONS

(continued)

7.8 SUSPENSION OF BENEFITS AND PREMIUMS.

- 1) **Suspension for Medicaid Eligibility.** If you are determined to be entitled to Medicaid, you may request to have this contract suspended for 24 months or, if earlier, until your entitlement to Medicaid ends. To suspend this contract, you must give us Written Notice within 90 days after entitlement for Medicaid begins.

If your entitlement ends and you give us Written Notice of that within 90 days after entitlement ends, we will reinstate your contract as of the date your entitlement ended. You must pay any premium due from the date entitlement ended. The reinstated contract will be the same as if no suspension had occurred.

- 2) **Suspension for Coverage under Social Security Act Section 226(b).** If you are disabled before age 65, entitled to disability benefits under Section 226(b) of the Social Security Act and covered under a group health plan as defined in the Social Security Act, you may request to have this contract suspended by giving us Written Notice.

If your coverage under the group health plan is terminated after this contract is suspended and you give us Written Notice of that within 90 days after termination, we will reinstate your contract as of the date of termination. You must pay any premium due from the date of termination of the group health coverage. The reinstated contract will be the same as if no suspension had occurred.

7.9 DIVIDENDS. Each year we will determine our divisible surplus. This contract's share, if any, will be credited as a dividend on the Contract Anniversary and paid to you in cash. Since we do not expect this contract to contribute to divisible surplus, it is not expected that any dividends will be credited.

7.10 TERMINATION. This contract will terminate at the earliest of the following dates:

- 1) The end of the grace period if any premium is then in default (see Section 6.4).
- 2) The date of your Written Notice to cancel this contract. The date of Written Notice is the date we receive it or, if later, the date you specify.
- 3) The date of death of the insured.

If this contract terminates, benefits for continuous losses that began while the contract was in force will continue while you are continuously totally disabled, as defined by the Social Security Act, but not beyond the end of the Medicare Benefit Period or the Calendar Year for which benefits would otherwise be payable under this contract. We will refund the portion of any premium paid for the period beyond the date of termination.

Medicare supplement insurance.
Guaranteed renewable for life.
Premiums expected to increase.

This certificate of membership and Medicare supplement insurance is a legal contract between you and Thrivent Financial for Lutherans. We issue this contract based on the signed Application and payment of the Initial Premium shown on page 3. We will pay benefits according to the provisions of this contract. Coverage begins at 12:01 a.m. on the Date of Issue or, if later, the date we receive the Initial Premium for this contract. It ends at 11:59 p.m. on the day this contract terminates (see Section 7.11).

This contract is guaranteed renewable for life. You may keep this contract in force, regardless of any change in health, by paying premiums when due. We cannot cancel this contract or reduce benefits other than as provided in Section 4.

Table of Premiums - Premiums May Change. The Initial Premium is shown on page 3. It applies to the first year of coverage. Renewal premiums will be charged according to our table of premiums in effect on each Contract Anniversary. We expect premiums to increase as Medicare benefits change and as health care costs increase. Premiums also depend on your place of residence. Any change in premiums will apply on a class basis to all contracts in force on this form in your state of residence. We will not change your premium due to changes in your health or due to any claims on this contract.

Notice to Buyer: This contract may not cover all of your medical expenses.

Right to Cancel. Please read this contract carefully. You may cancel the contract for any reason before midnight of the 30th day after you first receive it. Do this by (1) mailing or delivering Written Notice to our Service Center and (2) returning the contract. Notice given by mail and return of the contract by mail are effective on being postmarked, properly addressed and postage prepaid. If you cancel the contract, it will be deemed void from the beginning and we will refund any premium paid.

Important Notice - Statements in the Application. Please read the copy of the Application attached to this contract. This contract was issued on the basis that all information shown in the Application is correct and complete. Omissions or misstatements in the application could cause a claim to be denied or make this contract void. If any information shown is not correct or complete or if any past medical history has been left out of the Application, contact us immediately.

Caution: Except as provided in Section 2.5 Foreign Travel Emergency Benefit, this contract covers only those expenses that are approved for payment by Medicare.

Medicare supplement insurance.
Guaranteed renewable for life.
Premiums expected to increase.

Signed for the Society

President []

Secretary []

INSURED: [JOHN DOE]

AGE: [65] SEX: [MALE]

CONTRACT NUMBER: [H0012345]

DATE OF ISSUE: [JUNE 1, 2010]

Table of Contents

Cover Page
Index
Contract Schedule, Contract Data
Section 1 Definitions
Section 2 Benefits
Section 3 Exclusions
Section 4 Adjustments to Benefits
Section 5 Claims
Section 6 Premiums and Reinstatement
Section 7 General Provisions
Amendments, Endorsements, Application

Index

	Section		Section
Adjustments to Benefits	4	Part B Deductible Benefit	2
Basic Benefits	2	Payment of Claims	5
Benefit Appeals Procedure	5	Physical Examinations	5
Change of Contract	7	Premium in Default and Grace Period	6
Changes in Medicare	4	Premium Payments	6
Changes in Premium	6	Proof of Loss	5
Claim Forms	5	Reimbursement and Subrogation	5
Entire Contract	7	Reinstatement	6
Exclusions	3	Skilled Nursing Facility Benefit	2
Foreign Travel Emergency Benefit	2	Statements in the Application	7
Legal Proceedings	5	Suspension of Benefits and Premiums	7
Maintenance of Solvency	7	Termination	7
Membership	7	Time Limit on Certain Defenses	7
Notice of Claim	5	Time of Payment of Claims	5
Part A Deductible Benefit	2		

Contract Schedule

Telephone [(800) 847-4836]

	ANNUAL PREMIUM#
BASIC BENEFIT MEDICARE SUPPLEMENT INSURANCE - PLAN C	[\$X,XXX.00]
RISK CLASS: [STANDARD NON-TOBACCO]	
TOTAL ANNUAL PREMIUM	[\$X,XXX.00]
INTERVAL OF PAYMENT	[ANNUAL]
INITIAL PREMIUM	[\$X,XXX.00]

PREMIUMS ARE SUBJECT TO CHANGE ON EACH CONTRACT ANNIVERSARY. WE EXPECT PREMIUMS TO INCREASE AS MEDICARE BENEFITS CHANGE AND AS HEALTH CARE COSTS INCREASE. PREMIUMS DEPEND ON YOUR PLACE OF RESIDENCE.

INSURED: [JOHN DOE]

AGE: [65] SEX: [MALE]

CONTRACT NUMBER: [H0012345]

DATE OF ISSUE: [JUNE 1, 2010]

1. DEFINITIONS

Application. The application(s) and all application supplements and amendments to the Application.

Calendar Year. The period beginning on each January 1 and ending the following December 31.

Coinsurance. The percentage of Medicare Eligible Expenses you must pay after Medicare payments begin. Coinsurance does not include any Deductibles. Coinsurance percentages are set by Medicare.

Copayment. The fixed amount of Medicare Eligible Expenses you must pay after Medicare payments begin. Copayment amounts do not include any Deductibles. Copayment amounts are set each year by Medicare.

Contract Anniversary. The same month and day for years after issue as in the Date of Issue on page 3.

Deductible. A fixed amount of Medicare Eligible Expenses that is not paid by Medicare. The Part A Deductible applies to the first 60 days of Hospital confinement in each Medicare Benefit Period. The Part B Deductible applies to each Calendar Year. Deductible amounts are set each year by Medicare.

Doctor. A legally qualified and licensed practitioner of the healing arts who is practicing within the scope of his authority.

Explanation of Medicare Benefits Form. The statement supplied to you by Medicare that shows the action taken on your Medicare claim.

Hospital. A legally operated facility that is approved or is eligible to be approved for payment of Medicare benefits for hospitalization, and that:

- 1) Is accredited as a hospital by the Joint Commission on Accreditation of Hospitals; or
- 2) Provides
 - a) Either on its premises or in facilities available on a prearranged basis, medical, diagnostic and major surgical facilities under the supervision of a staff of one or more Doctors for the care and treatment of sick or injured patients on an inpatient basis; and
 - b) 24-hour nursing service.

Injury. Accidental bodily injury sustained while this contract is in force.

Issue Age. Your age on the Date of Issue of this contract.

Medicaid. The Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

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

Medicare Benefit Period. The period as determined by Medicare that begins the day you are admitted to a Hospital. It ends when you have been in neither a Hospital nor a Skilled Nursing Facility for at least 60 consecutive days.

Medicare Eligible Expenses. Expenses approved by Medicare as eligible for payment under Medicare.

Medicare Lifetime Reserve Days. Extra days of Hospital coverage provided under Medicare Part A and Part B. You may use this coverage after the first 90 days of Hospital coverage during a Medicare Benefit Period.

Medicare Part A. Part A of Medicare, also known as Medicare Hospital Insurance.

Medicare Part B. Part B of Medicare, also known as Medicare Supplementary Medical Insurance.

Service Center. The location where this contract is administered. The Service Center address is shown on page 3.

Sickness. Illness or disease that first manifests itself while the contract is in force.

Skilled Nursing Facility. A legally operated facility or that part of one that is approved or eligible to be approved for payment of Medicare benefits for skilled nursing facility care.

we, our, us, Society. Thrivent Financial for Lutherans.

Written Notice. A written request or notice signed by you and received in good order by us at our Service Center.

you, your, yours. The insured.

2. BENEFITS

CORE BENEFITS

2.1 BASIC BENEFITS. For Medicare Eligible Expenses you incur for treatment of Sickness or Injury, we will pay:

- 1) Medicare Part A expenses for hospitalization that are not covered by Medicare from the 61st day through the 90th day of confinement in a Medicare Benefit Period.
- 2) Medicare Part A expenses for hospitalization that are not covered by Medicare for each day that you use one of your Medicare Lifetime Reserve days.
- 3) If you are confined for more than 90 days and you have used all of your Medicare Lifetime Reserve Days, all Medicare Part A expenses for hospitalization, subject to a lifetime maximum benefit of an additional 365 days. Benefits will be paid at the applicable prospective payment system rate or other appropriate Medicare standard of payment.
- 4) Medicare Part A expenses for hospice and respite care that are not covered by Medicare.
- 5) Expenses for the first 3 pints of blood you receive under Medicare Parts A and B (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.
- 6) The Coinsurance portion of Medicare Part B expenses in any Calendar Year in excess of the Part B Deductible amount. For Hospital outpatient expenses paid under a prospective payment system, we will pay the Copayment amount.

ADDITIONAL BENEFITS

2.2 PART A DEDUCTIBLE BENEFIT. For each Medicare Benefit Period that you are confined in a Hospital as a result of Sickness or Injury, we will pay the Part A Deductible amount or, if less, the amount of Medicare Part A expenses that you incur.

2.3 SKILLED NURSING FACILITY BENEFIT. For each Medicare Benefit Period that you are confined in a Skilled Nursing Facility for post-Hospital care as a result of Sickness or Injury, we will pay the Copayment amount for the 21st through the 100th day of confinement provided that:

- 1) You were confined in a Hospital for at least 3 days; and
- 2) Confinement in a Skilled Nursing Facility began within 30 days after your Hospital confinement ended.

2.4 PART B DEDUCTIBLE BENEFIT. For each Calendar Year in which you incur Part B Medicare Eligible Expenses as a result of Sickness or Injury, we will pay the Part B Deductible amount or, if less, the amount of Medicare Part B expenses that you incur.

2.5 FOREIGN TRAVEL EMERGENCY BENEFIT. For each Calendar Year in which you travel outside the United States and receive medically necessary emergency hospital, physician or medical care in a foreign country, we will pay 80% of the billed charges in excess of a \$250 annual deductible for expenses that you incur for that care. Total benefits paid under this provision will not exceed \$50,000 for your lifetime.

For purposes of this provision:

- 1) Emergency care is care that is needed immediately as a result of an Injury or Sickness of sudden and unexpected onset. Benefits are payable only if:
 - a) The care would have been covered by Medicare had it been received in the United States; and
 - b) For each trip you make outside the United States, the care begins within 60 days of the day you left the United States.
- 2) Medically necessary care is care and treatment that is reasonable and appropriate for the diagnosis, care and treatment of your Sickness or Injury.
- 3) Physician does not include you or a member of your family.

3. EXCLUSIONS

3.1 EXCLUSIONS. Except as provided in Section 2.5 Foreign Travel Emergency Benefit, this contract covers only those expenses that are approved for payment by Medicare.

This contract does not cover expenses due to:

- 1) Care, treatment or supplies to the extent that you are entitled to have payment made under:
 - a) Medicare or any other governmental program (except Medicaid);

- b) Any other Medicare Supplement Insurance contract; or
- c) Any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law;
- 2) Services for which no charge is normally made in the absence of insurance; or
- 3) Items or services for which you have no legal obligation to pay.

4. ADJUSTMENTS TO BENEFITS

4.1 ADJUSTMENTS TO BENEFITS. At the beginning of each Calendar Year, we will adjust your benefits to reflect any changes in the Part A Deductible, Copayment amounts or the Part B Deductible. If an adjustment results in a change in premium, the new premium will be effective on the first Contract Anniversary after the adjustment in benefits. We will give you at least 30 days notice of any increase in premium.

4.2 CHANGES IN MEDICARE. Changes in Medicare, other than as in Section 4.1, that affect the coverage provided by this contract may require an adjustment in benefits and premiums.

5. CLAIMS

5.1 NOTICE OF CLAIM. A notice of claim must be given to us at our Service Center within 30 days after a covered loss starts or as soon after this as reasonably possible. Notice should include your name and contract number.

5.2 CLAIM FORMS. When we receive your notice of claim, we will send you information for filing proof of loss. If we do not send this information within 15 days, you may meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in Section 5.3.

5.3 PROOF OF LOSS. Proof of loss must be given to us at our Service Center. This should be done within 90 days after the loss occurs. Failure to give proof within 90 days will not affect the claim if proof is given as soon as is reasonably possible, but the proof must be given no later than one year from the time proof is otherwise required, unless you were legally incapacitated.

Before filing a claim for Part B Medicare Eligible Expenses under this contract, you must first file your claim with Medicare. Send us the Explanation of Medicare Benefits form that you receive from Medicare and the itemized bills from your health care providers. On dually assigned claims submitted by participating Doctors and suppliers, we will accept notice from the Medicare carriers as a claim for benefits in place of any other claim form otherwise required and we will make a payment determination based on the information contained in that notice.

5.4 TIME OF PAYMENT OF CLAIMS. We will pay benefits for losses covered under this contract as soon as we receive sufficient proof of loss.

5.5 PAYMENT OF CLAIMS. Benefits will be paid to you or to your health care provider to whom you have assigned benefits. Any benefits payable to you that are unpaid at your death will be paid to your estate.

5.6 PHYSICAL EXAMINATIONS. In addition to other proof of loss, we may require you to have physical examinations as often as reasonably necessary while a claim is pending or being paid. It will be at our expense.

5.7 BENEFIT APPEALS PROCEDURE. If you have a claim for benefits that is denied in whole or in part, you may appeal the claim denial by sending us a written request for review. Mail this request to our Service Center and enclose any information that you think will help us review your claim. Within 30 days after we receive your request, we will review your claim in detail and send you written notification of the results of the review.

5.8 LEGAL PROCEEDINGS. No legal proceeding to recover on this contract may be commenced until at least 60 days after written proof of loss has been given. No such proceeding may be commenced after 3 years from the time written proof of loss is required to be given.

5.9 REIMBURSEMENT AND SUBROGATION. If we pay any benefits for any expenses you incur due to any act of a third party who is or may become liable to you because of that act, then we are entitled to subrogation from the third party. If you recover from a third party, the reasonable costs of collection and attorney fees will be assessed against you and us in the proportion that each benefits from recovery.

You must provide us with timely written notice of any claim you make against a third party for payment or reimbursement of medical and medically-related expenses. At our option, we may take any action we deem appropriate to protect our rights under this reimbursement and subrogation provision including, without limitation, seeking to intervene in any lawsuit or other proceeding you have begun against a third party. The statute of limitations applicable to our right to seek reimbursement or subrogation does not begin to run until you have given us written notice.

6. PREMIUMS AND REINSTATEMENT

6.1 PREMIUM PAYMENTS. The Initial Premium amount and its Interval of Payment are shown on page 3. The Initial Premium is due and payable on the Date of Issue. Each subsequent premium is due on the first day of its Interval of Payment.

Premiums are payable at our Service Center. Upon request, we will give you a receipt, signed by an officer of the Society, for premium paid.

6.2 PREMIUM BILLING. We will send premium billings based upon the Interval of Payment that you request. Subject to our published rules, you may change the Interval of Payment or the method of billing by giving Written Notice.

6.3 CHANGES IN PREMIUM. We may change our table of premiums on any Contract Anniversary. Any change will apply to all like contracts in force in your state of residence. We will not change your premium because of a change in your health. If your premium changes because of a change in your place of residence, the new premium will be effective on the next premium due date after your change of residence. We will give you at least 30 days notice of any increase in premium.

6.4 PREMIUM IN DEFAULT AND GRACE PERIOD. Any premium not paid on or before the date it is due is a premium in default. Except for the Initial Premium, you may pay the premium in default within a grace period of 31 days after the date it is due. During the grace period, this contract will remain in force. If the premium in default is not paid within the grace period, this contract will terminate at the end of the grace period.

6.5 REINSTATEMENT. If this contract terminates as in Section 6.4, you must pay any premium in default to reinstate it. The contract is reinstated when we accept the payment, unless we also require an application for reinstatement.

If we require an application for reinstatement, we must give you notice of approval or disapproval within 45 days after the date of the application. We will reinstate the contract as soon as it is approved. If we do not notify you within this 45-day period, the contract will automatically be reinstated on the 45th day.

The reinstated contract will cover only losses that result from:

- 1) Injury sustained after the date of reinstatement; or
- 2) Sickness that first manifests itself after the date of reinstatement.

All other rights that you or we had immediately before the default in premium payments again apply, subject to any provisions endorsed on or attached to this contract when it is reinstated.

Section 7.4 Time Limit on Certain Defenses will apply from the date the contract is reinstated with regard to statements made in the application for reinstatement.

This contract cannot be reinstated after 5 months from the end of the grace period.

7. GENERAL PROVISIONS

7.1 ENTIRE CONTRACT. The Entire Contract consists of:

- 1) This contract including any attached riders, amendments or endorsements;
- 2) The Application attached to this contract; and
- 3) The Articles of Incorporation and Bylaws of the Society and all amendments to them.

Benefits will not be reduced by any future amendments to our Articles of Incorporation or Bylaws.

7.2 CHANGE OF CONTRACT. No change to this contract is valid unless it is made in writing and signed by our President or Secretary.

7.3 STATEMENTS IN THE APPLICATION. We will not use any statements to contest a claim or to have this contract declared invalid unless the statement is contained in the Application. All statements made in the Application are considered representations, not warranties.

7.4 TIME LIMIT ON CERTAIN DEFENSES.

- 1) **Misstatements in the Application.** After this contract has been in force during your lifetime for two years from the Date of Issue, no statement made in the Application, except fraudulent misrepresentation, shall be used to void this contract or deny a claim for loss incurred or disability that begins after the end of the two-year period.
- 2) **Pre-Existing Conditions.** No claim for loss incurred after the Date of Issue will be reduced or denied because a disease or physical condition existed before the Date of Issue.

This provision will apply from the date this contract is reinstated with regard to statements made in the application for reinstatement.

7.5 MAINTENANCE OF SOLVENCY. If the solvency of the Society becomes impaired, you may be required to make an extra payment. The Board of Directors will determine the amount of any extra payment. It will be based on each member's fair share of the deficiency.

7.6 MEMBERSHIP. You are a member of the Society. Rights and privileges of membership are set forth in the Articles of Incorporation and Bylaws of the Society. These rights and privileges are separate from ownership of this contract.

7.7 CONFORMITY WITH STATE STATUTES. On the Date of Issue, any provision of this contract in conflict with the laws of the state in which you reside on that date is amended to conform with those state laws.

7. GENERAL PROVISIONS**(continued)****7.8 SUSPENSION OF BENEFITS AND PREMIUMS.**

- 1) **Suspension for Medicaid Eligibility.** If you are determined to be entitled to Medicaid, you may request to have this contract suspended for 24 months or, if earlier, until your entitlement to Medicaid ends. To suspend this contract, you must give us Written Notice within 90 days after entitlement for Medicaid begins.

If your entitlement ends and you give us Written Notice of that within 90 days after entitlement ends, we will reinstate your contract as of the date your entitlement ended. You must pay any premium due from the date entitlement ended. The reinstated contract will be the same as if no suspension had occurred.

- 2) **Suspension for Coverage under Social Security Act Section 226(b).** If you are disabled before age 65, entitled to disability benefits under Section 226(b) of the Social Security Act and covered under a group health plan as defined in the Social Security Act, you may request to have this contract suspended by giving us Written Notice.

If your coverage under the group health plan is terminated after this contract is suspended and you give us Written Notice of that within 90 days after termination, we will reinstate your contract as of the date of termination. You must pay any premium due from the date of termination of the group health coverage. The reinstated contract will be the same as if no suspension had occurred.

7.9 DIVIDENDS. Each year we will determine our divisible surplus. This contract's share, if any, will be credited as a dividend on the Contract Anniversary and paid to you in cash. Since we do not expect this contract to contribute to divisible surplus, it is not expected that any dividends will be credited.

7.10 TERMINATION. This contract will terminate at the earliest of the following dates:

- 1) The end of the grace period if any premium is then in default (see Section 6.4).
- 2) The date of your Written Notice to cancel this contract. The date of Written Notice is the date we receive it or, if later, the date you specify.
- 3) The date of death of the insured.

If this contract terminates, benefits for continuous losses that began while the contract was in force will continue while you are continuously totally disabled, as defined by the Social Security Act, but not beyond the end of the Medicare Benefit Period or the Calendar Year for which benefits would otherwise be payable under this contract. We will refund the portion of any premium paid for the period beyond the date of termination.

Medicare supplement insurance.
Guaranteed renewable for life.
Premiums expected to increase.

This certificate of membership and Medicare supplement insurance is a legal contract between you and Thrivent Financial for Lutherans. We issue this contract based on the signed Application and payment of the Initial Premium shown on page 3. We will pay benefits according to the provisions of this contract. Coverage begins at 12:01 a.m. on the Date of Issue or, if later, the date we receive the Initial Premium for this contract. It ends at 11:59 p.m. on the day this contract terminates (see Section 7.11).

This contract is guaranteed renewable for life. You may keep this contract in force, regardless of any change in health, by paying premiums when due. We cannot cancel this contract or reduce benefits other than as provided in Section 4.

Table of Premiums - Premiums May Change. The Initial Premium is shown on page 3. It applies to the first year of coverage. Renewal premiums will be charged according to our table of premiums in effect on each Contract Anniversary. We expect premiums to increase as Medicare benefits change and as health care costs increase. Premiums also depend on your place of residence. Any change in premiums will apply on a class basis to all contracts in force on this form in your state of residence. We will not change your premium due to changes in your health or due to any claims on this contract.

Notice to Buyer: This contract may not cover all of your medical expenses.

Right to Cancel. Please read this contract carefully. You may cancel the contract for any reason before midnight of the 30th day after you first receive it. Do this by (1) mailing or delivering Written Notice to our Service Center and (2) returning the contract. Notice given by mail and return of the contract by mail are effective on being postmarked, properly addressed and postage prepaid. If you cancel the contract, it will be deemed void from the beginning and we will refund any premium paid.

Important Notice - Statements in the Application. Please read the copy of the Application attached to this contract. This contract was issued on the basis that all information shown in the Application is correct and complete. Omissions or misstatements in the application could cause a claim to be denied or make this contract void. If any information shown is not correct or complete or if any past medical history has been left out of the Application, contact us immediately.

Caution: Except as provided in Section 2.4 Foreign Travel Emergency Benefit, this contract covers only those expenses that are approved for payment by Medicare.

Medicare supplement insurance.
Guaranteed renewable for life.
Premiums expected to increase.

Signed for the Society

President []

Secretary []

INSURED: [JOHN DOE]

AGE: [65] SEX: [MALE]

CONTRACT NUMBER: [H0012345]

DATE OF ISSUE: [JUNE 1, 2010]

Table of Contents

Cover Page
Index
Contract Schedule, Contract Data
Section 1 Definitions
Section 2 Benefits
Section 3 Exclusions
Section 4 Adjustments to Benefits
Section 5 Claims
Section 6 Premiums and Reinstatement
Section 7 General Provisions
Amendments, Endorsements, Application

Index

	Section		Section
Adjustments to Benefits	4	Part A Deductible Benefit	2
Basic Benefits	2	Payment of Claims	5
Benefit Appeals Procedure	5	Physical Examinations	5
Change of Contract	7	Premium in Default and Grace Period	6
Changes in Medicare	4	Premium Payments	6
Changes in Premium	6	Proof of Loss	5
Claim Forms	5	Reimbursement and Subrogation	5
Entire Contract	7	Reinstatement	6
Exclusions	3	Skilled Nursing Facility Benefit	2
Foreign Travel Emergency Benefit	2	Statements in the Application	7
Legal Proceedings	5	Suspension of Benefits and Premiums	7
Maintenance of Solvency	7	Termination	7
Membership	7	Time Limit on Certain Defenses	7
Notice of Claim	5	Time of Payment of Claims	5

Contract Schedule

Telephone [(800) 847-4836]

	ANNUAL PREMIUM#
BASIC BENEFIT MEDICARE SUPPLEMENT INSURANCE - PLAN D	[\$X,XXX.00]
RISK CLASS: [STANDARD NON-TOBACCO]	
TOTAL ANNUAL PREMIUM	[\$X,XXX.00]
INTERVAL OF PAYMENT	[ANNUAL]
INITIAL PREMIUM	[\$X,XXX.00]

PREMIUMS ARE SUBJECT TO CHANGE ON EACH CONTRACT ANNIVERSARY. WE EXPECT PREMIUMS TO INCREASE AS MEDICARE BENEFITS CHANGE AND AS HEALTH CARE COSTS INCREASE. PREMIUMS DEPEND ON YOUR PLACE OF RESIDENCE.

INSURED: [JOHN DOE]

AGE: [65] SEX: [MALE]

CONTRACT NUMBER: [H0012345]

DATE OF ISSUE: [JUNE 1, 2010]

1. DEFINITIONS

Application. The application(s) and all application supplements and amendments to the Application.

Calendar Year. The period beginning on each January 1 and ending the following December 31.

Coinsurance. The percentage of Medicare Eligible Expenses you must pay after Medicare payments begin. Coinsurance does not include any Deductibles. Coinsurance percentages are set by Medicare.

Copayment. The fixed amount of Medicare Eligible Expenses you must pay after Medicare payments begin. Copayment amounts do not include any Deductibles. Copayment amounts are set each year by Medicare.

Contract Anniversary. The same month and day for years after issue as in the Date of Issue on page 3.

Deductible. A fixed amount of Medicare Eligible Expenses that is not paid by Medicare. The Part A Deductible applies to the first 60 days of Hospital confinement in each Medicare Benefit Period. The Part B Deductible applies to each Calendar Year. Deductible amounts are set each year by Medicare.

Doctor. A legally qualified and licensed practitioner of the healing arts who is practicing within the scope of his authority.

Explanation of Medicare Benefits Form. The statement supplied to you by Medicare that shows the action taken on your Medicare claim.

Hospital. A legally operated facility that is approved or is eligible to be approved for payment of Medicare benefits for hospitalization, and that:

- 1) Is accredited as a hospital by the Joint Commission on Accreditation of Hospitals; or
- 2) Provides
 - a) Either on its premises or in facilities available on a prearranged basis, medical, diagnostic and major surgical facilities under the supervision of a staff of one or more Doctors for the care and treatment of sick or injured patients on an inpatient basis; and
 - b) 24-hour nursing service.

Injury. Accidental bodily injury sustained while this contract is in force.

Issue Age. Your age on the Date of Issue of this contract.

Medicaid. The Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

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

Medicare Benefit Period. The period as determined by Medicare that begins the day you are admitted to a Hospital. It ends when you have been in neither a Hospital nor a Skilled Nursing Facility for at least 60 consecutive days.

Medicare Eligible Expenses. Expenses approved by Medicare as eligible for payment under Medicare.

Medicare Lifetime Reserve Days. Extra days of Hospital coverage provided under Medicare Part A and Part B. You may use this coverage after the first 90 days of Hospital coverage during a Medicare Benefit Period.

Medicare Part A. Part A of Medicare, also known as Medicare Hospital Insurance.

Medicare Part B. Part B of Medicare, also known as Medicare Supplementary Medical Insurance.

Service Center. The location where this contract is administered. The Service Center address is shown on page 3.

Sickness. Illness or disease that first manifests itself while the contract is in force.

Skilled Nursing Facility. A legally operated facility or that part of one that is approved or eligible to be approved for payment of Medicare benefits for skilled nursing facility care.

we, our, us, Society. Thrivent Financial for Lutherans.

Written Notice. A written request or notice signed by you and received in good order by us at our Service Center.

you, your, yours. The insured.

2. BENEFITS

CORE BENEFITS

2.1 BASIC BENEFITS. For Medicare Eligible Expenses you incur for treatment of Sickness or Injury, we will pay:

- 1) Medicare Part A expenses for hospitalization that are not covered by Medicare from the 61st day through the 90th day of confinement in a Medicare Benefit Period.
- 2) Medicare Part A expenses for hospitalization that are not covered by Medicare for each day that you use one of your Medicare Lifetime Reserve days.
- 3) If you are confined for more than 90 days and you have used all of your Medicare Lifetime Reserve Days, all Medicare Part A expenses for hospitalization, subject to a lifetime maximum benefit of an additional 365 days. Benefits will be paid at the applicable prospective payment system rate or other appropriate Medicare standard of payment.
- 4) Medicare Part A expenses for hospice and respite care that are not covered by Medicare.
- 5) Expenses for the first 3 pints of blood you receive under Medicare Parts A and B (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.
- 6) The Coinsurance portion of Medicare Part B expenses in any Calendar Year in excess of the Part B Deductible amount. For Hospital outpatient expenses paid under a prospective payment system, we will pay the Copayment amount.

ADDITIONAL BENEFITS

2.2 PART A DEDUCTIBLE BENEFIT. For each Medicare Benefit Period that you are confined in a Hospital as a result of Sickness or Injury, we will pay the Part A Deductible amount or, if less, the amount of Medicare Part A expenses that you incur.

2.3 SKILLED NURSING FACILITY BENEFIT. For each Medicare Benefit Period that you are confined in a Skilled Nursing Facility for post-Hospital care as a result of Sickness or Injury, we will pay the Copayment amount for the 21st through the 100th day of confinement provided that:

- 1) You were confined in a Hospital for at least 3 days; and
- 2) Confinement in a Skilled Nursing Facility began within 30 days after your Hospital confinement ended.

2.4 FOREIGN TRAVEL EMERGENCY BENEFIT. For each Calendar Year in which you travel outside the United States and receive medically necessary emergency hospital, physician or medical care in a foreign country, we will pay 80% of the billed charges in excess of a \$250 annual deductible for expenses that you incur for that care. Total benefits paid under this provision will not exceed \$50,000 for your lifetime.

For purposes of this provision:

- 1) Emergency care is care that is needed immediately as a result of an Injury or Sickness of sudden and unexpected onset. Benefits are payable only if:
 - a) The care would have been covered by Medicare had it been received in the United States; and
 - b) For each trip you make outside the United States, the care begins within 60 days of the day you left the United States.
- 2) Medically necessary care is care and treatment that is reasonable and appropriate for the diagnosis, care and treatment of your Sickness or Injury.
- 3) Physician does not include you or a member of your family.

3. EXCLUSIONS

3.1 EXCLUSIONS. Except as provided in Section 2.4 Foreign Travel Emergency Benefit, this contract covers only those expenses that are approved for payment by Medicare.

This contract does not cover expenses due to:

- 1) Care, treatment or supplies to the extent that you are entitled to have payment made under:
 - a) Medicare or any other governmental program (except Medicaid);

- b) Any other Medicare Supplement Insurance contract; or
- c) Any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law;
- 2) Services for which no charge is normally made in the absence of insurance; or
- 3) Items or services for which you have no legal obligation to pay.

4. ADJUSTMENTS TO BENEFITS

4.1 ADJUSTMENTS TO BENEFITS. At the beginning of each Calendar Year, we will adjust your benefits to reflect any changes in the Part A Deductible, Copayment amounts or the Part B Deductible. If an adjustment results in a change in premium, the new premium will be effective on the first Contract Anniversary after the adjustment in benefits. We will give you at least 30 days notice of any increase in premium.

4.2 CHANGES IN MEDICARE. Changes in Medicare, other than as in Section 4.1, that affect the coverage provided by this contract may require an adjustment in benefits and premiums.

5. CLAIMS

5.1 NOTICE OF CLAIM. A notice of claim must be given to us at our Service Center within 30 days after a covered loss starts or as soon after this as reasonably possible. Notice should include your name and contract number.

5.2 CLAIM FORMS. When we receive your notice of claim, we will send you information for filing proof of loss. If we do not send this information within 15 days, you may meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in Section 5.3.

5.3 PROOF OF LOSS. Proof of loss must be given to us at our Service Center. This should be done within 90 days after the loss occurs. Failure to give proof within 90 days will not affect the claim if proof is given as soon as is reasonably possible, but the proof must be given no later than one year from the time proof is otherwise required, unless you were legally incapacitated.

Before filing a claim for Part B Medicare Eligible Expenses under this contract, you must first file your claim with Medicare. Send us the Explanation of Medicare Benefits form that you receive from Medicare and the itemized bills from your health care providers. On dually assigned claims submitted by participating Doctors and suppliers, we will accept notice from the Medicare carriers as a claim for benefits in place of any other claim form otherwise required and we will make a payment determination based on the information contained in that notice.

5.4 TIME OF PAYMENT OF CLAIMS. We will pay benefits for losses covered under this contract as soon as we receive sufficient proof of loss.

5.5 PAYMENT OF CLAIMS. Benefits will be paid to you or to your health care provider to whom you have assigned benefits. Any benefits payable to you that are unpaid at your death will be paid to your estate.

5.6 PHYSICAL EXAMINATIONS. In addition to other proof of loss, we may require you to have physical examinations as often as reasonably necessary while a claim is pending or being paid. It will be at our expense.

5.7 BENEFIT APPEALS PROCEDURE. If you have a claim for benefits that is denied in whole or in part, you may appeal the claim denial by sending us a written request for review. Mail this request to our Service Center and enclose any information that you think will help us review your claim. Within 30 days after we receive your request, we will review your claim in detail and send you written notification of the results of the review.

5.8 LEGAL PROCEEDINGS. No legal proceeding to recover on this contract may be commenced until at least 60 days after written proof of loss has been given. No such proceeding may be commenced after 3 years from the time written proof of loss is required to be given.

5.9 REIMBURSEMENT AND SUBROGATION. If we pay any benefits for any expenses you incur due to any act of a third party who is or may become liable to you because of that act, then we are entitled to subrogation from the third party. If you recover from a third party, the reasonable costs of collection and attorney fees will be assessed against you and us in the proportion that each benefits from recovery.

You must provide us with timely written notice of any claim you make against a third party for payment or reimbursement of medical and medically-related expenses. At our option, we may take any action we deem appropriate to protect our rights under this reimbursement and subrogation provision including, without limitation, seeking to intervene in any lawsuit or other proceeding you have begun against a third party. The statute of limitations applicable to our right to seek reimbursement or subrogation does not begin to run until you have given us written notice.

6. PREMIUMS AND REINSTATEMENT

6.1 PREMIUM PAYMENTS. The Initial Premium amount and its Interval of Payment are shown on page 3. The Initial Premium is due and payable on the Date of Issue. Each subsequent premium is due on the first day of its Interval of Payment.

Premiums are payable at our Service Center. Upon request, we will give you a receipt, signed by an officer of the Society, for premium paid.

6.2 PREMIUM BILLING. We will send premium billings based upon the Interval of Payment that you request. Subject to our published rules, you may change the Interval of Payment or the method of billing by giving Written Notice.

6.3 CHANGES IN PREMIUM. We may change our table of premiums on any Contract Anniversary. Any change will apply to all like contracts in force in your state of residence. We will not change your premium because of a change in your health. If your premium changes because of a change in your place of residence, the new premium will be effective on the next premium due date after your change of residence. We will give you at least 30 days notice of any increase in premium.

6.4 PREMIUM IN DEFAULT AND GRACE PERIOD. Any premium not paid on or before the date it is due is a premium in default. Except for the Initial Premium, you may pay the premium in default within a grace period of 31 days after the date it is due. During the grace period, this contract will remain in force. If the premium in default is not paid within the grace period, this contract will terminate at the end of the grace period.

6.5 REINSTATEMENT. If this contract terminates as in Section 6.4, you must pay any premium in default to reinstate it. The contract is reinstated when we accept the payment, unless we also require an application for reinstatement.

If we require an application for reinstatement, we must give you notice of approval or disapproval within 45 days after the date of the application. We will reinstate the contract as soon as it is approved. If we do not notify you within this 45-day period, the contract will automatically be reinstated on the 45th day.

The reinstated contract will cover only losses that result from:

- 1) Injury sustained after the date of reinstatement; or
- 2) Sickness that first manifests itself after the date of reinstatement.

All other rights that you or we had immediately before the default in premium payments again apply, subject to any provisions endorsed on or attached to this contract when it is reinstated.

Section 7.4 Time Limit on Certain Defenses will apply from the date the contract is reinstated with regard to statements made in the application for reinstatement.

This contract cannot be reinstated after 5 months from the end of the grace period.

7. GENERAL PROVISIONS

7.1 ENTIRE CONTRACT. The Entire Contract consists of:

- 1) This contract including any attached riders, amendments or endorsements;
- 2) The Application attached to this contract; and
- 3) The Articles of Incorporation and Bylaws of the Society and all amendments to them.

Benefits will not be reduced by any future amendments to our Articles of Incorporation or Bylaws.

7.2 CHANGE OF CONTRACT. No change to this contract is valid unless it is made in writing and signed by our President or Secretary.

7.3 STATEMENTS IN THE APPLICATION. We will not use any statements to contest a claim or to have this contract declared invalid unless the statement is contained in the Application. All statements made in the Application are considered representations, not warranties.

7.4 TIME LIMIT ON CERTAIN DEFENSES.

- 1) **Misstatements in the Application.** After this contract has been in force during your lifetime for two years from the Date of Issue, no statement made in the Application, except fraudulent misrepresentation, shall be used to void this contract or deny a claim for loss incurred or disability that begins after the end of the two-year period.
- 2) **Pre-Existing Conditions.** No claim for loss incurred after the Date of Issue will be reduced or denied because a disease or physical condition existed before the Date of Issue.

This provision will apply from the date this contract is reinstated with regard to statements made in the application for reinstatement.

7.5 MAINTENANCE OF SOLVENCY. If the solvency of the Society becomes impaired, you may be required to make an extra payment. The Board of Directors will determine the amount of any extra payment. It will be based on each member's fair share of the deficiency.

7.6 MEMBERSHIP. You are a member of the Society. Rights and privileges of membership are set forth in the Articles of Incorporation and Bylaws of the Society. These rights and privileges are separate from ownership of this contract.

7.7 CONFORMITY WITH STATE STATUTES. On the Date of Issue, any provision of this contract in conflict with the laws of the state in which you reside on that date is amended to conform with those state laws.

7. GENERAL PROVISIONS**(continued)****7.8 SUSPENSION OF BENEFITS AND PREMIUMS.**

- 1) **Suspension for Medicaid Eligibility.** If you are determined to be entitled to Medicaid, you may request to have this contract suspended for 24 months or, if earlier, until your entitlement to Medicaid ends. To suspend this contract, you must give us Written Notice within 90 days after entitlement for Medicaid begins.

If your entitlement ends and you give us Written Notice of that within 90 days after entitlement ends, we will reinstate your contract as of the date your entitlement ended. You must pay any premium due from the date entitlement ended. The reinstated contract will be the same as if no suspension had occurred.

- 2) **Suspension for Coverage under Social Security Act Section 226(b).** If you are disabled before age 65, entitled to disability benefits under Section 226(b) of the Social Security Act and covered under a group health plan as defined in the Social Security Act, you may request to have this contract suspended by giving us Written Notice.

If your coverage under the group health plan is terminated after this contract is suspended and you give us Written Notice of that within 90 days after termination, we will reinstate your contract as of the date of termination. You must pay any premium due from the date of termination of the group health coverage. The reinstated contract will be the same as if no suspension had occurred.

7.9 DIVIDENDS. Each year we will determine our divisible surplus. This contract's share, if any, will be credited as a dividend on the Contract Anniversary and paid to you in cash. Since we do not expect this contract to contribute to divisible surplus, it is not expected that any dividends will be credited.

7.10 TERMINATION. This contract will terminate at the earliest of the following dates:

- 1) The end of the grace period if any premium is then in default (see Section 6.4).
- 2) The date of your Written Notice to cancel this contract. The date of Written Notice is the date we receive it or, if later, the date you specify.
- 3) The date of death of the insured.

If this contract terminates, benefits for continuous losses that began while the contract was in force will continue while you are continuously totally disabled, as defined by the Social Security Act, but not beyond the end of the Medicare Benefit Period or the Calendar Year for which benefits would otherwise be payable under this contract. We will refund the portion of any premium paid for the period beyond the date of termination.

Medicare supplement insurance.
Guaranteed renewable for life.
Premiums expected to increase.

This certificate of membership and Medicare supplement insurance is a legal contract between you and Thrivent Financial for Lutherans. We issue this contract based on the signed Application and payment of the Initial Premium shown on page 3. We will pay benefits according to the provisions of this contract. Coverage begins at 12:01 a.m. on the Date of Issue or, if later, the date we receive the Initial Premium for this contract. It ends at 11:59 p.m. on the day this contract terminates (see Section 7.11).

This contract is guaranteed renewable for life. You may keep this contract in force, regardless of any change in health, by paying premiums when due. We cannot cancel this contract or reduce benefits other than as provided in Section 4.

Table of Premiums - Premiums May Change. The Initial Premium is shown on page 3. It applies to the first year of coverage. Renewal premiums will be charged according to our table of premiums in effect on each Contract Anniversary. We expect premiums to increase as Medicare benefits change and as health care costs increase. Premiums also depend on your place of residence. Any change in premiums will apply on a class basis to all contracts in force on this form in your state of residence. We will not change your premium due to changes in your health or due to any claims on this contract.

Notice to Buyer: This contract may not cover all of your medical expenses.

Right to Cancel. Please read this contract carefully. You may cancel the contract for any reason before midnight of the 30th day after you first receive it. Do this by (1) mailing or delivering Written Notice to our Service Center and (2) returning the contract. Notice given by mail and return of the contract by mail are effective on being postmarked, properly addressed and postage prepaid. If you cancel the contract, it will be deemed void from the beginning and we will refund any premium paid.

Important Notice - Statements in the Application. Please read the copy of the Application attached to this contract. This contract was issued on the basis that all information shown in the Application is correct and complete. Omissions or misstatements in the application could cause a claim to be denied or make this contract void. If any information shown is not correct or complete or if any past medical history has been left out of the Application, contact us immediately.

Caution: Except as provided in Section 2.6 Foreign Travel Emergency Benefit, this contract covers only those expenses that are approved for payment by Medicare.

Medicare supplement insurance.
Guaranteed renewable for life.
Premiums expected to increase.

Signed for the Society

President []

Secretary []

INSURED: [JOHN DOE]

AGE: [65] SEX: [MALE]

CONTRACT NUMBER: [H0012345]

DATE OF ISSUE: [JUNE 1, 2010]

Table of Contents

Cover Page
 Index
 Contract Schedule, Contract Data
 Section 1 Definitions
 Section 2 Benefits
 Section 3 Exclusions
 Section 4 Adjustments to Benefits
 Section 5 Claims
 Section 6 Premiums and Reinstatement
 Section 7 General Provisions
 Amendments, Endorsements, Application

Index

	Section		Section
Adjustments to Benefits	4	Part B Deductible Benefit	2
Basic Benefits	2	Part B Excess Charges Benefit	2
Benefit Appeals Procedure	5	Payment of Claims	5
Change of Contract	7	Physical Examinations	5
Changes in Medicare	4	Premium in Default and Grace Period	6
Changes in Premium	6	Premium Payments	6
Claim Forms	5	Proof of Loss	5
Entire Contract	7	Reimbursement and Subrogation	5
Exclusions	3	Reinstatement	6
Foreign Travel Emergency Benefit	2	Skilled Nursing Facility Benefit	2
Legal Proceedings	5	Statements in the Application	7
Maintenance of Solvency	7	Suspension of Benefits and Premiums	7
Membership	7	Termination	7
Notice of Claim	5	Time Limit on Certain Defenses	7
Part A Deductible Benefit	2	Time of Payment of Claims	5

Contract Schedule

Telephone [(800) 847-4836]

	ANNUAL PREMIUM#
BASIC BENEFIT MEDICARE SUPPLEMENT INSURANCE - PLAN F	[\$X,XXX.00]
RISK CLASS: [STANDARD NON-TOBACCO]	
TOTAL ANNUAL PREMIUM	[\$X,XXX.00]
INTERVAL OF PAYMENT	[ANNUAL]
INITIAL PREMIUM	[\$X,XXX.00]

PREMIUMS ARE SUBJECT TO CHANGE ON EACH CONTRACT ANNIVERSARY. WE EXPECT PREMIUMS TO INCREASE AS MEDICARE BENEFITS CHANGE AND AS HEALTH CARE COSTS INCREASE. PREMIUMS DEPEND ON YOUR PLACE OF RESIDENCE.

INSURED: [JOHN DOE]

AGE: [65] SEX: [MALE]

CONTRACT NUMBER: [H0012345]

DATE OF ISSUE: [JUNE 1, 2010]

1. DEFINITIONS

Application. The application(s) and all application supplements and amendments to the Application.

Calendar Year. The period beginning on each January 1 and ending the following December 31.

Coinsurance. The percentage of Medicare Eligible Expenses you must pay after Medicare payments begin. Coinsurance does not include any Deductibles. Coinsurance percentages are set by Medicare.

Copayment. The fixed amount of Medicare Eligible Expenses you must pay after Medicare payments begin. Copayment amounts do not include any Deductibles. Copayment amounts are set each year by Medicare.

Contract Anniversary. The same month and day for years after issue as in the Date of Issue on page 3.

Deductible. A fixed amount of Medicare Eligible Expenses that is not paid by Medicare. The Part A Deductible applies to the first 60 days of Hospital confinement in each Medicare Benefit Period. The Part B Deductible applies to each Calendar Year. Deductible amounts are set each year by Medicare.

Doctor. A legally qualified and licensed practitioner of the healing arts who is practicing within the scope of his authority.

Explanation of Medicare Benefits Form. The statement supplied to you by Medicare that shows the action taken on your Medicare claim.

Hospital. A legally operated facility that is approved or is eligible to be approved for payment of Medicare benefits for hospitalization, and that:

- 1) Is accredited as a hospital by the Joint Commission on Accreditation of Hospitals; or
- 2) Provides
 - a) Either on its premises or in facilities available on a prearranged basis, medical, diagnostic and major surgical facilities under the supervision of a staff of one or more Doctors for the care and treatment of sick or injured patients on an inpatient basis; and
 - b) 24-hour nursing service.

Injury. Accidental bodily injury sustained while this contract is in force.

Issue Age. Your age on the Date of Issue of this contract.

Medicaid. The Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

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

Medicare Benefit Period. The period as determined by Medicare that begins the day you are admitted to a Hospital. It ends when you have been in neither a Hospital nor a Skilled Nursing Facility for at least 60 consecutive days.

Medicare Eligible Expenses. Expenses approved by Medicare as eligible for payment under Medicare.

Medicare Lifetime Reserve Days. Extra days of Hospital coverage provided under Medicare Part A and Part B. You may use this coverage after the first 90 days of Hospital coverage during a Medicare Benefit Period.

Medicare Part A. Part A of Medicare, also known as Medicare Hospital Insurance.

Medicare Part B. Part B of Medicare, also known as Medicare Supplementary Medical Insurance.

Service Center. The location where this contract is administered. The Service Center address is shown on page 3.

Sickness. Illness or disease that first manifests itself while the contract is in force.

Skilled Nursing Facility. A legally operated facility or that part of one that is approved or eligible to be approved for payment of Medicare benefits for skilled nursing facility care.

we, our, us, Society. Thrivent Financial for Lutherans.

Written Notice. A written request or notice signed by you and received in good order by us at our Service Center.

you, your, yours. The insured.

2. BENEFITS

CORE BENEFITS

2.1 BASIC BENEFITS. For Medicare Eligible Expenses you incur for treatment of Sickness or Injury, we will pay:

- 1) Medicare Part A expenses for hospitalization that are not covered by Medicare from the 61st day through the 90th day of confinement in a Medicare Benefit Period.
- 2) Medicare Part A expenses for hospitalization that are not covered by Medicare for each day that you use one of your Medicare Lifetime Reserve days.
- 3) If you are confined for more than 90 days and you have used all of your Medicare Lifetime Reserve Days, all Medicare Part A expenses for hospitalization, subject to a lifetime maximum benefit of an additional 365 days. Benefits will be paid at the applicable prospective payment system rate or other appropriate Medicare standard of payment.
- 4) Medicare Part A expenses for hospice and respite care that are not covered by Medicare.
- 5) Expenses for the first 3 pints of blood you receive under Medicare Parts A and B (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.
- 6) The Coinsurance portion of Medicare Part B expenses in any Calendar Year in excess of the Part B Deductible amount. For Hospital outpatient expenses paid under a prospective payment system, we will pay the Copayment amount.

ADDITIONAL BENEFITS

2.2 PART A DEDUCTIBLE BENEFIT. For each Medicare Benefit Period that you are confined in a Hospital as a result of Sickness or Injury, we will pay the Part A Deductible amount or, if less, the amount of Medicare Part A expenses that you incur.

2.3 SKILLED NURSING FACILITY BENEFIT. For each Medicare Benefit Period that you are confined in a Skilled Nursing Facility for post-Hospital care as a result of Sickness or Injury, we will pay the Copayment amount for the 21st through the 100th day of confinement provided that:

- 1) You were confined in a Hospital for at least 3 days; and
- 2) Confinement in a Skilled Nursing Facility began within 30 days after your Hospital confinement ended.

2.4 PART B DEDUCTIBLE BENEFIT. For each Calendar Year in which you incur Part B Medicare Eligible Expenses as a result of Sickness or Injury, we will pay the Part B Deductible amount or, if less, the amount of Medicare Part B expenses that you incur.

2.5 PART B EXCESS CHARGES BENEFIT. For each Calendar Year in which you incur Part B Medicare Eligible Expenses as a result of Sickness or Injury that are in excess of the Part B Deductible, we will pay:

- 1) The Medicare Part B charge; less
- 2) The amount of this charge that was approved by Medicare for payment under Medicare Part B.

The Medicare Part B charge will be the amount billed to you or, if less, the limit on that amount established by Medicare or by state law.

2. BENEFITS

(continued)**2.6 FOREIGN TRAVEL EMERGENCY BENEFIT.**

For each Calendar Year in which you travel outside the United States and receive medically necessary emergency hospital, physician or medical care in a foreign country, we will pay 80% of the billed charges in excess of a \$250 annual deductible for expenses that you incur for that care. Total benefits paid under this provision will not exceed \$50,000 for your lifetime.

For purposes of this provision:

- 1) Emergency care is care that is needed immediately as a result of an Injury or Sickness of sudden and unexpected onset. Benefits are payable only if:
 - a) The care would have been covered by Medicare had it been received in the United States; and
 - b) For each trip you make outside the United States, the care begins within 60 days of the day you left the United States.
- 2) Medically necessary care is care and treatment that is reasonable and appropriate for the diagnosis, care and treatment of your Sickness or Injury.
- 3) Physician does not include you or a member of your family.

3. EXCLUSIONS

3.1 EXCLUSIONS. Except as provided in Section 2.6 Foreign Travel Emergency Benefit, this contract covers only those expenses that are approved for payment by Medicare.

This contract does not cover expenses due to:

- 1) Care, treatment or supplies to the extent that you are entitled to have payment made under:
 - a) Medicare or any other governmental program (except Medicaid);
 - b) Any other Medicare Supplement Insurance contract; or
 - c) Any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law;
- 2) Services for which no charge is normally made in the absence of insurance; or
- 3) Items or services for which you have no legal obligation to pay.

4. ADJUSTMENTS TO BENEFITS

4.1 ADJUSTMENTS TO BENEFITS. At the beginning of each Calendar Year, we will adjust your benefits to reflect any changes in the Part A Deductible, Copayment amounts or the Part B Deductible. If an adjustment results in a change in premium, the new premium will be effective on the first Contract Anniversary after the adjustment in benefits. We will give you at least 30 days notice of any increase in premium.

4.2 CHANGES IN MEDICARE. Changes in Medicare, other than as in Section 4.1, that affect the coverage provided by this contract may require an adjustment in benefits and premiums.

5. CLAIMS

5.1 NOTICE OF CLAIM. A notice of claim must be given to us at our Service Center within 30 days after a covered loss starts or as soon after this as reasonably possible. Notice should include your name and contract number.

5.2 CLAIM FORMS. When we receive your notice of claim, we will send you information for filing proof of loss. If we do not send this information within 15 days, you may meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in Section 5.3.

5.3 PROOF OF LOSS. Proof of loss must be given to us at our Service Center. This should be done within 90 days after the loss occurs. Failure to give proof within 90 days will not affect the claim if proof is given as soon as is reasonably possible, but the proof must be given no later than one year from the time proof is otherwise required, unless you were legally incapacitated.

Before filing a claim for Part B Medicare Eligible Expenses under this contract, you must first file your claim with Medicare. Send us the Explanation of Medicare Benefits form that you receive from Medicare and the itemized bills from your health care providers. On dually assigned claims submitted by participating Doctors and suppliers, we will accept notice from the Medicare carriers as a claim for benefits in place of any other claim form otherwise required and we will make a payment determination based on the information contained in that notice.

5.4 TIME OF PAYMENT OF CLAIMS. We will pay benefits for losses covered under this contract as soon as we receive sufficient proof of loss.

5.5 PAYMENT OF CLAIMS. Benefits will be paid to you or to your health care provider to whom you have assigned benefits. Any benefits payable to you that are unpaid at your death will be paid to your estate.

5.6 PHYSICAL EXAMINATIONS. In addition to other proof of loss, we may require you to have physical examinations as often as reasonably necessary while a claim is pending or being paid. It will be at our expense.

5.7 BENEFIT APPEALS PROCEDURE. If you have a claim for benefits that is denied in whole or in part, you may appeal the claim denial by sending us a written request for review. Mail this request to our Service Center and enclose any information that you think will help us review your claim. Within 30 days after we receive your request, we will review your claim in detail and send you written notification of the results of the review.

5.8 LEGAL PROCEEDINGS. No legal proceeding to recover on this contract may be commenced until at least 60 days after written proof of loss has been given. No such proceeding may be commenced after 3 years from the time written proof of loss is required to be given.

5.9 REIMBURSEMENT AND SUBROGATION. If we pay any benefits for any expenses you incur due to any act of a third party who is or may become liable to you because of that act, then we are entitled to subrogation from the third party. If you recover from a third party, the reasonable costs of collection and attorney fees will be assessed against you and us in the proportion that each benefits from recovery.

You must provide us with timely written notice of any claim you make against a third party for payment or reimbursement of medical and medically-related expenses. At our option, we may take any action we deem appropriate to protect our rights under this reimbursement and subrogation provision including, without limitation, seeking to intervene in any lawsuit or other proceeding you have begun against a third party. The statute of limitations applicable to our right to seek reimbursement or subrogation does not begin to run until you have given us written notice.

6. PREMIUMS AND REINSTATEMENT

6.1 PREMIUM PAYMENTS. The Initial Premium amount and its Interval of Payment are shown on page 3. The Initial Premium is due and payable on the Date of Issue. Each subsequent premium is due on the first day of its Interval of Payment.

Premiums are payable at our Service Center. Upon request, we will give you a receipt, signed by an officer of the Society, for premium paid.

6.2 PREMIUM BILLING. We will send premium billings based upon the Interval of Payment that you request. Subject to our published rules, you may change the Interval of Payment or the method of billing by giving Written Notice.

6.3 CHANGES IN PREMIUM. We may change our table of premiums on any Contract Anniversary. Any change will apply to all like contracts in force in your state of residence. We will not change your premium because of a change in your health. If your premium changes because of a change in your place of residence, the new premium will be effective on the next premium due date after your change of residence. We will give you at least 30 days notice of any increase in premium.

6.4 PREMIUM IN DEFAULT AND GRACE PERIOD. Any premium not paid on or before the date it is due is a premium in default. Except for the Initial Premium, you may pay the premium in default within a grace period of 31 days after the date it is due. During the grace period, this contract will remain in force. If the premium in default is not paid within the grace period, this contract will terminate at the end of the grace period.

6.5 REINSTATEMENT. If this contract terminates as in Section 6.4, you must pay any premium in default to reinstate it. The contract is reinstated when we accept the payment, unless we also require an application for reinstatement.

If we require an application for reinstatement, we must give you notice of approval or disapproval within 45 days after the date of the application. We will reinstate the contract as soon as it is approved. If we do not notify you within this 45-day period, the contract will automatically be reinstated on the 45th day.

The reinstated contract will cover only losses that result from:

- 1) Injury sustained after the date of reinstatement; or
- 2) Sickness that first manifests itself after the date of reinstatement.

All other rights that you or we had immediately before the default in premium payments again apply, subject to any provisions endorsed on or attached to this contract when it is reinstated.

Section 7.4 Time Limit on Certain Defenses will apply from the date the contract is reinstated with regard to statements made in the application for reinstatement.

This contract cannot be reinstated after 5 months from the end of the grace period.

7. GENERAL PROVISIONS

7.1 ENTIRE CONTRACT. The Entire Contract consists of:

- 1) This contract including any attached riders, amendments or endorsements;
- 2) The Application attached to this contract; and
- 3) The Articles of Incorporation and Bylaws of the Society and all amendments to them.

Benefits will not be reduced by any future amendments to our Articles of Incorporation or Bylaws.

7.2 CHANGE OF CONTRACT. No change to this contract is valid unless it is made in writing and signed by our President or Secretary.

7.3 STATEMENTS IN THE APPLICATION. We will not use any statements to contest a claim or to have this contract declared invalid unless the statement is contained in the Application. All statements made in the Application are considered representations, not warranties.

7.4 TIME LIMIT ON CERTAIN DEFENSES.

- 1) **Misstatements in the Application.** After this contract has been in force during your lifetime for two years from the Date of Issue, no statement made in the Application, except fraudulent misrepresentation, shall be used to void this contract or deny a claim for loss incurred or disability that begins after the end of the two-year period.
- 2) **Pre-Existing Conditions.** No claim for loss incurred after the Date of Issue will be reduced or denied because a disease or physical condition existed before the Date of Issue.

This provision will apply from the date this contract is reinstated with regard to statements made in the application for reinstatement.

7.5 MAINTENANCE OF SOLVENCY. If the solvency of the Society becomes impaired, you may be required to make an extra payment. The Board of Directors will determine the amount of any extra payment. It will be based on each member's fair share of the deficiency.

7.6 MEMBERSHIP. You are a member of the Society. Rights and privileges of membership are set forth in the Articles of Incorporation and Bylaws of the Society. These rights and privileges are separate from ownership of this contract.

7.7 CONFORMITY WITH STATE STATUTES. On the Date of Issue, any provision of this contract in conflict with the laws of the state in which you reside on that date is amended to conform with those state laws.

7. GENERAL PROVISIONS**(continued)****7.8 SUSPENSION OF BENEFITS AND PREMIUMS.**

- 1) **Suspension for Medicaid Eligibility.** If you are determined to be entitled to Medicaid, you may request to have this contract suspended for 24 months or, if earlier, until your entitlement to Medicaid ends. To suspend this contract, you must give us Written Notice within 90 days after entitlement for Medicaid begins.

If your entitlement ends and you give us Written Notice of that within 90 days after entitlement ends, we will reinstate your contract as of the date your entitlement ended. You must pay any premium due from the date entitlement ended. The reinstated contract will be the same as if no suspension had occurred.

- 2) **Suspension for Coverage under Social Security Act Section 226(b).** If you are disabled before age 65, entitled to disability benefits under Section 226(b) of the Social Security Act and covered under a group health plan as defined in the Social Security Act, you may request to have this contract suspended by giving us Written Notice.

If your coverage under the group health plan is terminated after this contract is suspended and you give us Written Notice of that within 90 days after termination, we will reinstate your contract as of the date of termination. You must pay any premium due from the date of termination of the group health coverage. The reinstated contract will be the same as if no suspension had occurred.

7.9 DIVIDENDS. Each year we will determine our divisible surplus. This contract's share, if any, will be credited as a dividend on the Contract Anniversary and paid to you in cash. Since we do not expect this contract to contribute to divisible surplus, it is not expected that any dividends will be credited.

7.10 TERMINATION. This contract will terminate at the earliest of the following dates:

- 1) The end of the grace period if any premium is then in default (see Section 6.4).
- 2) The date of your Written Notice to cancel this contract. The date of Written Notice is the date we receive it or, if later, the date you specify.
- 3) The date of death of the insured.

If this contract terminates, benefits for continuous losses that began while the contract was in force will continue while you are continuously totally disabled, as defined by the Social Security Act, but not beyond the end of the Medicare Benefit Period or the Calendar Year for which benefits would otherwise be payable under this contract. We will refund the portion of any premium paid for the period beyond the date of termination.

Medicare supplement insurance.
Guaranteed renewable for life.
Premiums expected to increase.

This certificate of membership and Medicare supplement insurance is a legal contract between you and Thrivent Financial for Lutherans. We issue this contract based on the signed Application and payment of the Initial Premium shown on page 3. We will pay benefits according to the provisions of this contract. Coverage begins at 12:01 a.m. on the Date of Issue or, if later, the date we receive the Initial Premium for this contract. It ends at 11:59 p.m. on the day this contract terminates (see Section 7.11).

This contract is guaranteed renewable for life. You may keep this contract in force, regardless of any change in health, by paying premiums when due. We cannot cancel this contract or reduce benefits other than as provided in Section 4.

Table of Premiums - Premiums May Change. The Initial Premium is shown on page 3. It applies to the first year of coverage. Renewal premiums will be charged according to our table of premiums in effect on each Contract Anniversary. We expect premiums to increase as Medicare benefits change and as health care costs increase. Premiums also depend on your place of residence. Any change in premiums will apply on a class basis to all contracts in force on this form in your state of residence. We will not change your premium due to changes in your health or due to any claims on this contract.

Notice to Buyer: This contract may not cover all of your medical expenses.

Right to Cancel. Please read this contract carefully. You may cancel the contract for any reason before midnight of the 30th day after you first receive it. Do this by (1) mailing or delivering Written Notice to our Service Center and (2) returning the contract. Notice given by mail and return of the contract by mail are effective on being postmarked, properly addressed and postage prepaid. If you cancel the contract, it will be deemed void from the beginning and we will refund any premium paid.

Important Notice - Statements in the Application. Please read the copy of the Application attached to this contract. This contract was issued on the basis that all information shown in the Application is correct and complete. Omissions or misstatements in the application could cause a claim to be denied or make this contract void. If any information shown is not correct or complete or if any past medical history has been left out of the Application, contact us immediately.

Caution: Except as provided in Section 2.6 Foreign Travel Emergency Benefit, this contract covers only those expenses that are approved for payment by Medicare.

Medicare supplement insurance.
Guaranteed renewable for life.
Premiums expected to increase.

Signed for the Society

President []
Secretary []

INSURED: [JOHN DOE]

AGE: [65] SEX: [MALE]

CONTRACT NUMBER: [H0012345]

DATE OF ISSUE: [JUNE 1, 2010]

Table of Contents

Cover Page
 Index
 Contract Schedule, Contract Data
 Section 1 Definitions
 Section 2 Benefits
 Section 3 Exclusions
 Section 4 Adjustments to Benefits
 Section 5 Claims
 Section 6 Premiums and Reinstatement
 Section 7 General Provisions
 Amendments, Endorsements, Application

Index

	Section		Section
Adjustments to Benefits	4	Part B Deductible Benefit	2
Basic Benefits	2	Part B Excess Charges Benefit	2
Benefit Appeals Procedure	5	Payment of Claims	5
Change of Contract	7	Physical Examinations	5
Changes in Medicare	4	Premium in Default and Grace Period	6
Changes in Premium	6	Premium Payments	6
Claim Forms	5	Proof of Loss	5
Entire Contract	7	Reimbursement and Subrogation	5
Exclusions	3	Reinstatement	6
Foreign Travel Emergency Benefit	2	Skilled Nursing Facility Benefit	2
Legal Proceedings	5	Statements in the Application	7
Maintenance of Solvency	7	Suspension of Benefits and Premiums	7
Membership	7	Termination	7
Notice of Claim	5	Time Limit on Certain Defenses	7
Part A Deductible Benefit	2	Time of Payment of Claims	5

Contract Schedule

Telephone [(800) 847-4836]

	ANNUAL PREMIUM#
BASIC BENEFIT	
MEDICARE SUPPLEMENT INSURANCE - HIGH DEDUCTIBLE PLAN F	[\$X,XXX.00]
RISK CLASS: [STANDARD NON-TOBACCO]	
TOTAL ANNUAL PREMIUM	[\$X,XXX.00]
INTERVAL OF PAYMENT	[ANNUAL]
INITIAL PREMIUM	[\$X,XXX.00]

PREMIUMS ARE SUBJECT TO CHANGE ON EACH CONTRACT ANNIVERSARY. WE EXPECT PREMIUMS TO INCREASE AS MEDICARE BENEFITS CHANGE AND AS HEALTH CARE COSTS INCREASE. PREMIUMS DEPEND ON YOUR PLACE OF RESIDENCE.

INSURED: [JOHN DOE]

AGE: [65] SEX: [MALE]

CONTRACT NUMBER: [H0012345]

DATE OF ISSUE: [JUNE 1, 2010]

1. DEFINITIONS

Application. The application(s) and all application supplements and amendments to the Application.

Calendar Year. The period beginning on each January 1 and ending the following December 31.

Coinsurance. The percentage of Medicare Eligible Expenses you must pay after Medicare payments begin. Coinsurance does not include any Deductibles. Coinsurance percentages are set by Medicare.

Copayment. The fixed amount of Medicare Eligible Expenses you must pay after Medicare payments begin. Copayment amounts do not include any Deductibles. Copayment amounts are set each year by Medicare.

Contract Anniversary. The same month and day for years after issue as in the Date of Issue on page 3.

Deductible. A fixed amount of Medicare Eligible Expenses that is not paid by Medicare. The Part A Deductible applies to the first 60 days of Hospital confinement in each Medicare Benefit Period. The Part B Deductible applies to each Calendar Year. Deductible amounts are set each year by Medicare.

Doctor. A legally qualified and licensed practitioner of the healing arts who is practicing within the scope of his authority.

Explanation of Medicare Benefits Form. The statement supplied to you by Medicare that shows the action taken on your Medicare claim.

Hospital. A legally operated facility that is approved or is eligible to be approved for payment of Medicare benefits for hospitalization, and that:

- 1) Is accredited as a hospital by the Joint Commission on Accreditation of Hospitals; or
- 2) Provides
 - a) Either on its premises or in facilities available on a prearranged basis, medical, diagnostic and major surgical facilities under the supervision of a staff of one or more Doctors for the care and treatment of sick or injured patients on an inpatient basis; and
 - b) 24-hour nursing service.

Injury. Accidental bodily injury sustained while this contract is in force.

Issue Age. Your age on the Date of Issue of this contract.

Medicaid. The Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

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

Medicare Benefit Period. The period as determined by Medicare that begins the day you are admitted to a Hospital. It ends when you have been in neither a Hospital nor a Skilled Nursing Facility for at least 60 consecutive days.

Medicare Eligible Expenses. Expenses approved by Medicare as eligible for payment under Medicare.

Medicare Lifetime Reserve Days. Extra days of Hospital coverage provided under Medicare Part A and Part B. You may use this coverage after the first 90 days of Hospital coverage during a Medicare Benefit Period.

Medicare Part A. Part A of Medicare, also known as Medicare Hospital Insurance.

Medicare Part B. Part B of Medicare, also known as Medicare Supplementary Medical Insurance.

Service Center. The location where this contract is administered. The Service Center address is shown on page 3.

Sickness. Illness or disease that first manifests itself while the contract is in force.

Skilled Nursing Facility. A legally operated facility or that part of one that is approved or eligible to be approved for payment of Medicare benefits for skilled nursing facility care.

we, our, us, Society. Thrivent Financial for Lutherans.

Written Notice. A written request or notice signed by you and received in good order by us at our Service Center.

you, your, yours. The insured.

2. BENEFITS

In each Calendar Year, benefits under Sections 2.1 through 2.5 are payable only after you have met the deductible for that year. Prior to meeting the deductible in a Calendar Year, expenses that you incur that would be covered under Sections 2.1 through 2.5 if the deductible had already been met will count toward meeting the deductible. The deductible is set each year by Medicare.

CORE BENEFITS

2.1 BASIC BENEFITS. For Medicare Eligible Expenses you incur for treatment of Sickness or Injury, we will pay:

- 1) Medicare Part A expenses for hospitalization that are not covered by Medicare from the 61st day through the 90th day of confinement in a Medicare Benefit Period.
- 2) Medicare Part A expenses for hospitalization that are not covered by Medicare for each day that you use one of your Medicare Lifetime Reserve days.
- 3) If you are confined for more than 90 days and you have used all of your Medicare Lifetime Reserve Days, all Medicare Part A expenses for hospitalization, subject to a lifetime maximum benefit of an additional 365 days. Benefits will be paid at the applicable prospective payment system rate or other appropriate Medicare standard of payment.
- 4) Medicare Part A expenses for hospice and respite care that are not covered by Medicare.
- 5) Expenses for the first 3 pints of blood you receive under Medicare Parts A and B (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.
- 6) The Coinsurance portion of Medicare Part B expenses in any Calendar Year in excess of the Part B Deductible amount. For Hospital outpatient expenses paid under a prospective payment system, we will pay the Copayment amount.

ADDITIONAL BENEFITS

2.2 PART A DEDUCTIBLE BENEFIT. For each Medicare Benefit Period that you are confined in a Hospital as a result of Sickness or Injury, we will pay the Part A Deductible amount or, if less, the amount of Medicare Part A expenses that you incur.

2.3 SKILLED NURSING FACILITY BENEFIT. For each Medicare Benefit Period that you are confined in a Skilled Nursing Facility for post-Hospital care as a result of Sickness or Injury, we will pay the Copayment amount for the 21st through the 100th day of confinement provided that:

- 1) You were confined in a Hospital for at least 3 days; and
- 2) Confinement in a Skilled Nursing Facility began within 30 days after your Hospital confinement ended.

2.4 PART B DEDUCTIBLE BENEFIT. For each Calendar Year in which you incur Part B Medicare Eligible Expenses as a result of Sickness or Injury, we will pay the Part B Deductible amount or, if less, the amount of Medicare Part B expenses that you incur.

2.5 PART B EXCESS CHARGES BENEFIT. For each Calendar Year in which you incur Part B Medicare Eligible Expenses as a result of Sickness or Injury that are in excess of the Part B Deductible, we will pay:

- 1) The Medicare Part B charge; less
- 2) The amount of this charge that was approved by Medicare for payment under Medicare Part B.

The Medicare Part B charge will be the amount billed to you or, if less, the limit on that amount established by Medicare or by state law.

2. BENEFITS

(continued)

2.6 FOREIGN TRAVEL EMERGENCY BENEFIT. For each Calendar Year in which you travel outside the United States and receive medically necessary emergency hospital, physician or medical care in a foreign country, we will pay 80% of the billed charges in excess of a \$250 annual deductible for expenses that you incur for that care. This deductible is separate from the deductible that applies to Sections 2.1 through 2.5 of this contract. Total benefits paid under this provision will not exceed \$50,000 for your lifetime.

For purposes of this provision:

- 1) Emergency care is care that is needed immediately as a result of an Injury or Sickness of sudden and unexpected onset. Benefits are payable only if:
 - a) The care would have been covered by Medicare had it been received in the United States; and
 - b) For each trip you make outside the United States, the care begins within 60 days of the day you left the United States.
- 2) Medically necessary care is care and treatment that is reasonable and appropriate for the diagnosis, care and treatment of your Sickness or Injury.
- 3) Physician does not include you or a member of your family.

3. EXCLUSIONS

3.1 EXCLUSIONS. Except as provided in Section 2.6 Foreign Travel Emergency Benefit, this contract covers only those expenses that are approved for payment by Medicare.

This contract does not cover expenses due to:

- 1) Care, treatment or supplies to the extent that you are entitled to have payment made under:
 - a) Medicare or any other governmental program (except Medicaid);
 - b) Any other Medicare Supplement Insurance contract; or
 - c) Any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law;
- 2) Services for which no charge is normally made in the absence of insurance; or
- 3) Items or services for which you have no legal obligation to pay.

4. ADJUSTMENTS TO BENEFITS

4.1 ADJUSTMENTS TO BENEFITS. At the beginning of each Calendar Year, we will adjust your benefits to reflect any changes in the Part A Deductible, Copayment amounts or the Part B Deductible. If an adjustment results in a change in premium, the new premium will be effective on the first Contract Anniversary after the adjustment in benefits. We will give you at least 30 days notice of any increase in premium.

4.2 CHANGES IN MEDICARE. Changes in Medicare, other than as in Section 4.1, that affect the coverage provided by this contract may require an adjustment in benefits and premiums.

5. CLAIMS

5.1 NOTICE OF CLAIM. A notice of claim must be given to us at our Service Center within 30 days after a covered loss starts or as soon after this as reasonably possible. Notice should include your name and contract number.

5.2 CLAIM FORMS. When we receive your notice of claim, we will send you information for filing proof of loss. If we do not send this information within 15 days, you may meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in Section 5.3.

5.3 PROOF OF LOSS. Proof of loss must be given to us at our Service Center. This should be done within 90 days after the loss occurs. Failure to give proof within 90 days will not affect the claim if proof is given as soon as is reasonably possible, but the proof must be given no later than one year from the time proof is otherwise required, unless you were legally incapacitated.

Before filing a claim for Part B Medicare Eligible Expenses under this contract, you must first file your claim with Medicare. Send us the Explanation of Medicare Benefits form that you receive from Medicare and the itemized bills from your health care providers. On dually assigned claims submitted by participating Doctors and suppliers, we will accept notice from the Medicare carriers as a claim for benefits in place of any other claim form otherwise required and we will make a payment determination based on the information contained in that notice.

5.4 TIME OF PAYMENT OF CLAIMS. We will pay benefits for losses covered under this contract as soon as we receive sufficient proof of loss.

5.5 PAYMENT OF CLAIMS. Benefits will be paid to you or to your health care provider to whom you have assigned benefits. Any benefits payable to you that are unpaid at your death will be paid to your estate.

5.6 PHYSICAL EXAMINATIONS. In addition to other proof of loss, we may require you to have physical examinations as often as reasonably necessary while a claim is pending or being paid. It will be at our expense.

5.7 BENEFIT APPEALS PROCEDURE. If you have a claim for benefits that is denied in whole or in part, you may appeal the claim denial by sending us a written request for review. Mail this request to our Service Center and enclose any information that you think will help us review your claim. Within 30 days after we receive your request, we will review your claim in detail and send you written notification of the results of the review.

5.8 LEGAL PROCEEDINGS. No legal proceeding to recover on this contract may be commenced until at least 60 days after written proof of loss has been given. No such proceeding may be commenced after 3 years from the time written proof of loss is required to be given.

5.9 REIMBURSEMENT AND SUBROGATION. If we pay any benefits for any expenses you incur due to any act of a third party who is or may become liable to you because of that act, then we are entitled to subrogation from the third party. If you recover from a third party, the reasonable costs of collection and attorney fees will be assessed against you and us in the proportion that each benefits from recovery.

You must provide us with timely written notice of any claim you make against a third party for payment or reimbursement of medical and medically-related expenses. At our option, we may take any action we deem appropriate to protect our rights under this reimbursement and subrogation provision including, without limitation, seeking to intervene in any lawsuit or other proceeding you have begun against a third party. The statute of limitations applicable to our right to seek reimbursement or subrogation does not begin to run until you have given us written notice.

6. PREMIUMS AND REINSTATEMENT

6.1 PREMIUM PAYMENTS. The Initial Premium amount and its Interval of Payment are shown on page 3. The Initial Premium is due and payable on the Date of Issue. Each subsequent premium is due on the first day of its Interval of Payment.

Premiums are payable at our Service Center. Upon request, we will give you a receipt, signed by an officer of the Society, for premium paid.

6.2 PREMIUM BILLING. We will send premium billings based upon the Interval of Payment that you request. Subject to our published rules, you may change the Interval of Payment or the method of billing by giving Written Notice.

6.3 CHANGES IN PREMIUM. We may change our table of premiums on any Contract Anniversary. Any change will apply to all like contracts in force in your state of residence. We will not change your premium because of a change in your health. If your premium changes because of a change in your place of residence, the new premium will be effective on the next premium due date after your change of residence. We will give you at least 30 days notice of any increase in premium.

6.4 PREMIUM IN DEFAULT AND GRACE PERIOD. Any premium not paid on or before the date it is due is a premium in default. Except for the Initial Premium, you may pay the premium in default within a grace period of 31 days after the date it is due. During the grace period, this contract will remain in force. If the premium in default is not paid within the grace period, this contract will terminate at the end of the grace period.

6.5 REINSTATEMENT. If this contract terminates as in Section 6.4, you must pay any premium in default to reinstate it. The contract is reinstated when we accept the payment, unless we also require an application for reinstatement.

If we require an application for reinstatement, we must give you notice of approval or disapproval within 45 days after the date of the application. We will reinstate the contract as soon as it is approved. If we do not notify you within this 45-day period, the contract will automatically be reinstated on the 45th day.

The reinstated contract will cover only losses that result from:

- 1) Injury sustained after the date of reinstatement; or
- 2) Sickness that first manifests itself after the date of reinstatement.

All other rights that you or we had immediately before the default in premium payments again apply, subject to any provisions endorsed on or attached to this contract when it is reinstated.

Section 7.4 Time Limit on Certain Defenses will apply from the date the contract is reinstated with regard to statements made in the application for reinstatement.

This contract cannot be reinstated after 5 months from the end of the grace period.

7. GENERAL PROVISIONS

7.1 ENTIRE CONTRACT. The Entire Contract consists of:

- 1) This contract including any attached riders, amendments or endorsements;
- 2) The Application attached to this contract; and
- 3) The Articles of Incorporation and Bylaws of the Society and all amendments to them.

Benefits will not be reduced by any future amendments to our Articles of Incorporation or Bylaws.

7.2 CHANGE OF CONTRACT. No change to this contract is valid unless it is made in writing and signed by our President or Secretary.

7.3 STATEMENTS IN THE APPLICATION. We will not use any statements to contest a claim or to have this contract declared invalid unless the statement is contained in the Application. All statements made in the Application are considered representations, not warranties.

7.4 TIME LIMIT ON CERTAIN DEFENSES.

- 1) **Misstatements in the Application.** After this contract has been in force during your lifetime for two years from the Date of Issue, no statement made in the Application, except fraudulent misrepresentation, shall be used to void this contract or deny a claim for loss incurred or disability that begins after the end of the two-year period.
- 2) **Pre-Existing Conditions.** No claim for loss incurred after the Date of Issue will be reduced or denied because a disease or physical condition existed before the Date of Issue.

This provision will apply from the date this contract is reinstated with regard to statements made in the application for reinstatement.

7.5 MAINTENANCE OF SOLVENCY. If the solvency of the Society becomes impaired, you may be required to make an extra payment. The Board of Directors will determine the amount of any extra payment. It will be based on each member's fair share of the deficiency.

7.6 MEMBERSHIP. You are a member of the Society. Rights and privileges of membership are set forth in the Articles of Incorporation and Bylaws of the Society. These rights and privileges are separate from ownership of this contract.

7.7 CONFORMITY WITH STATE STATUTES. On the Date of Issue, any provision of this contract in conflict with the laws of the state in which you reside on that date is amended to conform with those state laws.

7. GENERAL PROVISIONS**(continued)****7.8 SUSPENSION OF BENEFITS AND PREMIUMS.**

- 1) **Suspension for Medicaid Eligibility.** If you are determined to be entitled to Medicaid, you may request to have this contract suspended for 24 months or, if earlier, until your entitlement to Medicaid ends. To suspend this contract, you must give us Written Notice within 90 days after entitlement for Medicaid begins.

If your entitlement ends and you give us Written Notice of that within 90 days after entitlement ends, we will reinstate your contract as of the date your entitlement ended. You must pay any premium due from the date entitlement ended. The reinstated contract will be the same as if no suspension had occurred.

- 2) **Suspension for Coverage under Social Security Act Section 226(b).** If you are disabled before age 65, entitled to disability benefits under Section 226(b) of the Social Security Act and covered under a group health plan as defined in the Social Security Act, you may request to have this contract suspended by giving us Written Notice.

If your coverage under the group health plan is terminated after this contract is suspended and you give us Written Notice of that within 90 days after termination, we will reinstate your contract as of the date of termination. You must pay any premium due from the date of termination of the group health coverage. The reinstated contract will be the same as if no suspension had occurred.

7.9 DIVIDENDS. Each year we will determine our divisible surplus. This contract's share, if any, will be credited as a dividend on the Contract Anniversary and paid to you in cash. Since we do not expect this contract to contribute to divisible surplus, it is not expected that any dividends will be credited.

7.10 TERMINATION. This contract will terminate at the earliest of the following dates:

- 1) The end of the grace period if any premium is then in default (see Section 6.4).
- 2) The date of your Written Notice to cancel this contract. The date of Written Notice is the date we receive it or, if later, the date you specify.
- 3) The date of death of the insured.

If this contract terminates, benefits for continuous losses that began while the contract was in force will continue while you are continuously totally disabled, as defined by the Social Security Act, but not beyond the end of the Medicare Benefit Period or the Calendar Year for which benefits would otherwise be payable under this contract. We will refund the portion of any premium paid for the period beyond the date of termination.

Medicare supplement insurance.
Guaranteed renewable for life.
Premiums expected to increase.

This certificate of membership and Medicare supplement insurance is a legal contract between you and Thrivent Financial for Lutherans. We issue this contract based on the signed Application and payment of the Initial Premium shown on page 3. We will pay benefits according to the provisions of this contract. Coverage begins at 12:01 a.m. on the Date of Issue or, if later, the date we receive the Initial Premium for this contract. It ends at 11:59 p.m. on the day this contract terminates (see Section 7.11).

This contract is guaranteed renewable for life. You may keep this contract in force, regardless of any change in health, by paying premiums when due. We cannot cancel this contract or reduce benefits other than as provided in Section 4.

Table of Premiums - Premiums May Change. The Initial Premium is shown on page 3. It applies to the first year of coverage. Renewal premiums will be charged according to our table of premiums in effect on each Contract Anniversary. We expect premiums to increase as Medicare benefits change and as health care costs increase. Premiums also depend on your place of residence. Any change in premiums will apply on a class basis to all contracts in force on this form in your state of residence. We will not change your premium due to changes in your health or due to any claims on this contract.

Notice to Buyer: This contract may not cover all of your medical expenses.

Right to Cancel. Please read this contract carefully. You may cancel the contract for any reason before midnight of the 30th day after you first receive it. Do this by (1) mailing or delivering Written Notice to our Service Center and (2) returning the contract. Notice given by mail and return of the contract by mail are effective on being postmarked, properly addressed and postage prepaid. If you cancel the contract, it will be deemed void from the beginning and we will refund any premium paid.

Important Notice - Statements in the Application. Please read the copy of the Application attached to this contract. This contract was issued on the basis that all information shown in the Application is correct and complete. Omissions or misstatements in the application could cause a claim to be denied or make this contract void. If any information shown is not correct or complete or if any past medical history has been left out of the Application, contact us immediately.

Caution: Except as provided in Section 2.5 Foreign Travel Emergency Benefit, this contract covers only those expenses that are approved for payment by Medicare.

Medicare supplement insurance.
Guaranteed renewable for life.
Premiums expected to increase.

Signed for the Society

President []

Secretary []

INSURED: [JOHN DOE]

AGE: [65] SEX: [MALE]

CONTRACT NUMBER: [H0012345]

DATE OF ISSUE: [JUNE 1, 2010]

Table of Contents

Cover Page
 Index
 Contract Schedule, Contract Data
 Section 1 Definitions
 Section 2 Benefits
 Section 3 Exclusions
 Section 4 Adjustments to Benefits
 Section 5 Claims
 Section 6 Premiums and Reinstatement
 Section 7 General Provisions
 Amendments, Endorsements, Application

Index

	Section		Section
Adjustments to Benefits	4	Part B Excess Charges Benefit	2
Basic Benefits	2	Payment of Claims	5
Benefit Appeals Procedure	5	Physical Examinations	5
Change of Contract	7	Premium in Default and Grace Period	6
Changes in Medicare	4	Premium Payments	6
Changes in Premium	6	Proof of Loss	5
Claim Forms	5	Reimbursement and Subrogation	5
Entire Contract	7	Reinstatement	6
Exclusions	3	Skilled Nursing Facility Benefit	2
Foreign Travel Emergency Benefit	2	Statements in the Application	7
Legal Proceedings	5	Suspension of Benefits and Premiums	7
Maintenance of Solvency	7	Termination	7
Membership	7	Time Limit on Certain Defenses	7
Notice of Claim	5	Time of Payment of Claims	5
Part A Deductible Benefit	2		

Contract Schedule

Telephone [(800) 847-4836]

	ANNUAL PREMIUM#
BASIC BENEFIT MEDICARE SUPPLEMENT INSURANCE - PLAN G	[\$X,XXX.00]
RISK CLASS: [STANDARD NON-TOBACCO]	
TOTAL ANNUAL PREMIUM	[\$X,XXX.00]
INTERVAL OF PAYMENT	[ANNUAL]
INITIAL PREMIUM	[\$X,XXX.00]

PREMIUMS ARE SUBJECT TO CHANGE ON EACH CONTRACT ANNIVERSARY. WE EXPECT PREMIUMS TO INCREASE AS MEDICARE BENEFITS CHANGE AND AS HEALTH CARE COSTS INCREASE. PREMIUMS DEPEND ON YOUR PLACE OF RESIDENCE.

INSURED: [JOHN DOE]

AGE: [65] SEX: [MALE]

CONTRACT NUMBER: [H0012345]

DATE OF ISSUE: [JUNE 1, 2010]

1. DEFINITIONS

Application. The application(s) and all application supplements and amendments to the Application.

Calendar Year. The period beginning on each January 1 and ending the following December 31.

Coinsurance. The percentage of Medicare Eligible Expenses you must pay after Medicare payments begin. Coinsurance does not include any Deductibles. Coinsurance percentages are set by Medicare.

Copayment. The fixed amount of Medicare Eligible Expenses you must pay after Medicare payments begin. Copayment amounts do not include any Deductibles. Copayment amounts are set each year by Medicare.

Contract Anniversary. The same month and day for years after issue as in the Date of Issue on page 3.

Deductible. A fixed amount of Medicare Eligible Expenses that is not paid by Medicare. The Part A Deductible applies to the first 60 days of Hospital confinement in each Medicare Benefit Period. The Part B Deductible applies to each Calendar Year. Deductible amounts are set each year by Medicare.

Doctor. A legally qualified and licensed practitioner of the healing arts who is practicing within the scope of his authority.

Explanation of Medicare Benefits Form. The statement supplied to you by Medicare that shows the action taken on your Medicare claim.

Hospital. A legally operated facility that is approved or is eligible to be approved for payment of Medicare benefits for hospitalization, and that:

- 1) Is accredited as a hospital by the Joint Commission on Accreditation of Hospitals; or
- 2) Provides
 - a) Either on its premises or in facilities available on a prearranged basis, medical, diagnostic and major surgical facilities under the supervision of a staff of one or more Doctors for the care and treatment of sick or injured patients on an inpatient basis; and
 - b) 24-hour nursing service.

Injury. Accidental bodily injury sustained while this contract is in force.

Issue Age. Your age on the Date of Issue of this contract.

Medicaid. The Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

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

Medicare Benefit Period. The period as determined by Medicare that begins the day you are admitted to a Hospital. It ends when you have been in neither a Hospital nor a Skilled Nursing Facility for at least 60 consecutive days.

Medicare Eligible Expenses. Expenses approved by Medicare as eligible for payment under Medicare.

Medicare Lifetime Reserve Days. Extra days of Hospital coverage provided under Medicare Part A and Part B. You may use this coverage after the first 90 days of Hospital coverage during a Medicare Benefit Period.

Medicare Part A. Part A of Medicare, also known as Medicare Hospital Insurance.

Medicare Part B. Part B of Medicare, also known as Medicare Supplementary Medical Insurance.

Service Center. The location where this contract is administered. The Service Center address is shown on page 3.

Sickness. Illness or disease that first manifests itself while the contract is in force.

Skilled Nursing Facility. A legally operated facility or that part of one that is approved or eligible to be approved for payment of Medicare benefits for skilled nursing facility care.

we, our, us, Society. Thrivent Financial for Lutherans.

Written Notice. A written request or notice signed by you and received in good order by us at our Service Center.

you, your, yours. The insured.

2. BENEFITS

CORE BENEFITS

2.1 BASIC BENEFITS. For Medicare Eligible Expenses you incur for treatment of Sickness or Injury, we will pay:

- 1) Medicare Part A expenses for hospitalization that are not covered by Medicare from the 61st day through the 90th day of confinement in a Medicare Benefit Period.
- 2) Medicare Part A expenses for hospitalization that are not covered by Medicare for each day that you use one of your Medicare Lifetime Reserve days.
- 3) If you are confined for more than 90 days and you have used all of your Medicare Lifetime Reserve Days, all Medicare Part A expenses for hospitalization, subject to a lifetime maximum benefit of an additional 365 days. Benefits will be paid at the applicable prospective payment system rate or other appropriate Medicare standard of payment.
- 4) Medicare Part A expenses for hospice and respite care that are not covered by Medicare.
- 5) Expenses for the first 3 pints of blood you receive under Medicare Parts A and B (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.
- 6) The Coinsurance portion of Medicare Part B expenses in any Calendar Year in excess of the Part B Deductible amount. For Hospital outpatient expenses paid under a prospective payment system, we will pay the Copayment amount.

ADDITIONAL BENEFITS

2.2 PART A DEDUCTIBLE BENEFIT. For each Medicare Benefit Period that you are confined in a Hospital as a result of Sickness or Injury, we will pay the Part A Deductible amount or, if less, the amount of Medicare Part A expenses that you incur.

2.3 SKILLED NURSING FACILITY BENEFIT. For each Medicare Benefit Period that you are confined in a Skilled Nursing Facility for post-Hospital care as a result of Sickness or Injury, we will pay the Copayment amount for the 21st through the 100th day of confinement provided that:

- 1) You were confined in a Hospital for at least 3 days; and
- 2) Confinement in a Skilled Nursing Facility began within 30 days after your Hospital confinement ended.

2.4 PART B EXCESS CHARGES BENEFIT. For each Calendar Year in which you incur Part B Medicare Eligible Expenses as a result of Sickness or Injury that are in excess of the Part B Deductible, we will pay:

- 1) The Medicare Part B charge; less
- 2) The amount of this charge that was approved by Medicare for payment under Medicare Part B.

The Medicare Part B charge will be the amount billed to you or, if less, the limit on that amount established by Medicare or by state law.

2. BENEFITS

(continued)**2.5 FOREIGN TRAVEL EMERGENCY BENEFIT.**

For each Calendar Year in which you travel outside the United States and receive medically necessary emergency hospital, physician or medical care in a foreign country, we will pay 80% of the billed charges in excess of a \$250 annual deductible for expenses that you incur for that care. Total benefits paid under this provision will not exceed \$50,000 for your lifetime.

For purposes of this provision:

- 1) Emergency care is care that is needed immediately as a result of an Injury or Sickness of sudden and unexpected onset. Benefits are payable only if:
 - a) The care would have been covered by Medicare had it been received in the United States; and
 - b) For each trip you make outside the United States, the care begins within 60 days of the day you left the United States.
- 2) Medically necessary care is care and treatment that is reasonable and appropriate for the diagnosis, care and treatment of your Sickness or Injury.
- 3) Physician does not include you or a member of your family.

3. EXCLUSIONS

3.1 EXCLUSIONS. Except as provided in Section 2.5 Foreign Travel Emergency Benefit, this contract covers only those expenses that are approved for payment by Medicare.

This contract does not cover expenses due to:

- 1) Care, treatment or supplies to the extent that you are entitled to have payment made under:
 - a) Medicare or any other governmental program (except Medicaid);
 - b) Any other Medicare Supplement Insurance contract; or
 - c) Any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law;
- 2) Services for which no charge is normally made in the absence of insurance; or
- 3) Items or services for which you have no legal obligation to pay.

4. ADJUSTMENTS TO BENEFITS

4.1 ADJUSTMENTS TO BENEFITS. At the beginning of each Calendar Year, we will adjust your benefits to reflect any changes in the Part A Deductible, Copayment amounts or the Part B Deductible. If an adjustment results in a change in premium, the new premium will be effective on the first Contract Anniversary after the adjustment in benefits. We will give you at least 30 days notice of any increase in premium.

4.2 CHANGES IN MEDICARE. Changes in Medicare, other than as in Section 4.1, that affect the coverage provided by this contract may require an adjustment in benefits and premiums.

5. CLAIMS

5.1 NOTICE OF CLAIM. A notice of claim must be given to us at our Service Center within 30 days after a covered loss starts or as soon after this as reasonably possible. Notice should include your name and contract number.

5.2 CLAIM FORMS. When we receive your notice of claim, we will send you information for filing proof of loss. If we do not send this information within 15 days, you may meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in Section 5.3.

5.3 PROOF OF LOSS. Proof of loss must be given to us at our Service Center. This should be done within 90 days after the loss occurs. Failure to give proof within 90 days will not affect the claim if proof is given as soon as is reasonably possible, but the proof must be given no later than one year from the time proof is otherwise required, unless you were legally incapacitated.

Before filing a claim for Part B Medicare Eligible Expenses under this contract, you must first file your claim with Medicare. Send us the Explanation of Medicare Benefits form that you receive from Medicare and the itemized bills from your health care providers. On dually assigned claims submitted by participating Doctors and suppliers, we will accept notice from the Medicare carriers as a claim for benefits in place of any other claim form otherwise required and we will make a payment determination based on the information contained in that notice.

5.4 TIME OF PAYMENT OF CLAIMS. We will pay benefits for losses covered under this contract as soon as we receive sufficient proof of loss.

5.5 PAYMENT OF CLAIMS. Benefits will be paid to you or to your health care provider to whom you have assigned benefits. Any benefits payable to you that are unpaid at your death will be paid to your estate.

5.6 PHYSICAL EXAMINATIONS. In addition to other proof of loss, we may require you to have physical examinations as often as reasonably necessary while a claim is pending or being paid. It will be at our expense.

5.7 BENEFIT APPEALS PROCEDURE. If you have a claim for benefits that is denied in whole or in part, you may appeal the claim denial by sending us a written request for review. Mail this request to our Service Center and enclose any information that you think will help us review your claim. Within 30 days after we receive your request, we will review your claim in detail and send you written notification of the results of the review.

5.8 LEGAL PROCEEDINGS. No legal proceeding to recover on this contract may be commenced until at least 60 days after written proof of loss has been given. No such proceeding may be commenced after 3 years from the time written proof of loss is required to be given.

5.9 REIMBURSEMENT AND SUBROGATION. If we pay any benefits for any expenses you incur due to any act of a third party who is or may become liable to you because of that act, then we are entitled to subrogation from the third party. If you recover from a third party, the reasonable costs of collection and attorney fees will be assessed against you and us in the proportion that each benefits from recovery.

You must provide us with timely written notice of any claim you make against a third party for payment or reimbursement of medical and medically-related expenses. At our option, we may take any action we deem appropriate to protect our rights under this reimbursement and subrogation provision including, without limitation, seeking to intervene in any lawsuit or other proceeding you have begun against a third party. The statute of limitations applicable to our right to seek reimbursement or subrogation does not begin to run until you have given us written notice.

6. PREMIUMS AND REINSTATEMENT

6.1 PREMIUM PAYMENTS. The Initial Premium amount and its Interval of Payment are shown on page 3. The Initial Premium is due and payable on the Date of Issue. Each subsequent premium is due on the first day of its Interval of Payment.

Premiums are payable at our Service Center. Upon request, we will give you a receipt, signed by an officer of the Society, for premium paid.

6.2 PREMIUM BILLING. We will send premium billings based upon the Interval of Payment that you request. Subject to our published rules, you may change the Interval of Payment or the method of billing by giving Written Notice.

6.3 CHANGES IN PREMIUM. We may change our table of premiums on any Contract Anniversary. Any change will apply to all like contracts in force in your state of residence. We will not change your premium because of a change in your health. If your premium changes because of a change in your place of residence, the new premium will be effective on the next premium due date after your change of residence. We will give you at least 30 days notice of any increase in premium.

6.4 PREMIUM IN DEFAULT AND GRACE PERIOD. Any premium not paid on or before the date it is due is a premium in default. Except for the Initial Premium, you may pay the premium in default within a grace period of 31 days after the date it is due. During the grace period, this contract will remain in force. If the premium in default is not paid within the grace period, this contract will terminate at the end of the grace period.

6.5 REINSTATEMENT. If this contract terminates as in Section 6.4, you must pay any premium in default to reinstate it. The contract is reinstated when we accept the payment, unless we also require an application for reinstatement.

If we require an application for reinstatement, we must give you notice of approval or disapproval within 45 days after the date of the application. We will reinstate the contract as soon as it is approved. If we do not notify you within this 45-day period, the contract will automatically be reinstated on the 45th day.

The reinstated contract will cover only losses that result from:

- 1) Injury sustained after the date of reinstatement; or
- 2) Sickness that first manifests itself after the date of reinstatement.

All other rights that you or we had immediately before the default in premium payments again apply, subject to any provisions endorsed on or attached to this contract when it is reinstated.

Section 7.4 Time Limit on Certain Defenses will apply from the date the contract is reinstated with regard to statements made in the application for reinstatement.

This contract cannot be reinstated after 5 months from the end of the grace period.

7. GENERAL PROVISIONS

7.1 ENTIRE CONTRACT. The Entire Contract consists of:

- 1) This contract including any attached riders, amendments or endorsements;
- 2) The Application attached to this contract; and
- 3) The Articles of Incorporation and Bylaws of the Society and all amendments to them.

Benefits will not be reduced by any future amendments to our Articles of Incorporation or Bylaws.

7.2 CHANGE OF CONTRACT. No change to this contract is valid unless it is made in writing and signed by our President or Secretary.

7.3 STATEMENTS IN THE APPLICATION. We will not use any statements to contest a claim or to have this contract declared invalid unless the statement is contained in the Application. All statements made in the Application are considered representations, not warranties.

7.4 TIME LIMIT ON CERTAIN DEFENSES.

- 1) **Misstatements in the Application.** After this contract has been in force during your lifetime for two years from the Date of Issue, no statement made in the Application, except fraudulent misrepresentation, shall be used to void this contract or deny a claim for loss incurred or disability that begins after the end of the two-year period.
- 2) **Pre-Existing Conditions.** No claim for loss incurred after the Date of Issue will be reduced or denied because a disease or physical condition existed before the Date of Issue.

This provision will apply from the date this contract is reinstated with regard to statements made in the application for reinstatement.

7.5 MAINTENANCE OF SOLVENCY. If the solvency of the Society becomes impaired, you may be required to make an extra payment. The Board of Directors will determine the amount of any extra payment. It will be based on each member's fair share of the deficiency.

7.6 MEMBERSHIP. You are a member of the Society. Rights and privileges of membership are set forth in the Articles of Incorporation and Bylaws of the Society. These rights and privileges are separate from ownership of this contract.

7.7 CONFORMITY WITH STATE STATUTES. On the Date of Issue, any provision of this contract in conflict with the laws of the state in which you reside on that date is amended to conform with those state laws.

7. GENERAL PROVISIONS**(continued)****7.8 SUSPENSION OF BENEFITS AND PREMIUMS.**

- 1) **Suspension for Medicaid Eligibility.** If you are determined to be entitled to Medicaid, you may request to have this contract suspended for 24 months or, if earlier, until your entitlement to Medicaid ends. To suspend this contract, you must give us Written Notice within 90 days after entitlement for Medicaid begins.

If your entitlement ends and you give us Written Notice of that within 90 days after entitlement ends, we will reinstate your contract as of the date your entitlement ended. You must pay any premium due from the date entitlement ended. The reinstated contract will be the same as if no suspension had occurred.

- 2) **Suspension for Coverage under Social Security Act Section 226(b).** If you are disabled before age 65, entitled to disability benefits under Section 226(b) of the Social Security Act and covered under a group health plan as defined in the Social Security Act, you may request to have this contract suspended by giving us Written Notice.

If your coverage under the group health plan is terminated after this contract is suspended and you give us Written Notice of that within 90 days after termination, we will reinstate your contract as of the date of termination. You must pay any premium due from the date of termination of the group health coverage. The reinstated contract will be the same as if no suspension had occurred.

7.9 DIVIDENDS. Each year we will determine our divisible surplus. This contract's share, if any, will be credited as a dividend on the Contract Anniversary and paid to you in cash. Since we do not expect this contract to contribute to divisible surplus, it is not expected that any dividends will be credited.

7.10 TERMINATION. This contract will terminate at the earliest of the following dates:

- 1) The end of the grace period if any premium is then in default (see Section 6.4).
- 2) The date of your Written Notice to cancel this contract. The date of Written Notice is the date we receive it or, if later, the date you specify.
- 3) The date of death of the insured.

If this contract terminates, benefits for continuous losses that began while the contract was in force will continue while you are continuously totally disabled, as defined by the Social Security Act, but not beyond the end of the Medicare Benefit Period or the Calendar Year for which benefits would otherwise be payable under this contract. We will refund the portion of any premium paid for the period beyond the date of termination.

Medicare supplement insurance.
Guaranteed renewable for life.
Premiums expected to increase.

This certificate of membership and Medicare supplement insurance is a legal contract between you and Thrivent Financial for Lutherans. We issue this contract based on the signed Application and payment of the Initial Premium shown on page 3. We will pay benefits according to the provisions of this contract. Coverage begins at 12:01 a.m. on the Date of Issue or, if later, the date we receive the Initial Premium for this contract. It ends at 11:59 p.m. on the day this contract terminates (see Section 7.11).

This contract is guaranteed renewable for life. You may keep this contract in force, regardless of any change in health, by paying premiums when due. We cannot cancel this contract or reduce benefits other than as provided in Section 4.

Table of Premiums - Premiums May Change. The Initial Premium is shown on page 3. It applies to the first year of coverage. Renewal premiums will be charged according to our table of premiums in effect on each Contract Anniversary. We expect premiums to increase as Medicare benefits change and as health care costs increase. Premiums also depend on your place of residence. Any change in premiums will apply on a class basis to all contracts in force on this form in your state of residence. We will not change your premium due to changes in your health or due to any claims on this contract.

Notice to Buyer: This contract may not cover all of your medical expenses.

Right to Cancel. Please read this contract carefully. You may cancel the contract for any reason before midnight of the 30th day after you first receive it. Do this by (1) mailing or delivering Written Notice to our Service Center and (2) returning the contract. Notice given by mail and return of the contract by mail are effective on being postmarked, properly addressed and postage prepaid. If you cancel the contract, it will be deemed void from the beginning and we will refund any premium paid.

Important Notice - Statements in the Application. Please read the copy of the Application attached to this contract. This contract was issued on the basis that all information shown in the Application is correct and complete. Omissions or misstatements in the application could cause a claim to be denied or make this contract void. If any information shown is not correct or complete or if any past medical history has been left out of the Application, contact us immediately.

Caution: This contract covers only those expenses that are approved for payment by Medicare.

Medicare supplement insurance.
Guaranteed renewable for life.
Premiums expected to increase.

Signed for the Society

President []

Secretary []

INSURED: [JOHN DOE]

AGE: [65] SEX: [MALE]

CONTRACT NUMBER: [H0012345]

DATE OF ISSUE: [JUNE 1, 2010]

Table of Contents

Cover Page
Index
Contract Schedule, Contract Data
Section 1 Definitions
Section 2 Benefits
Section 3 Exclusions
Section 4 Adjustments to Benefits
Section 5 Claims
Section 6 Premiums and Reinstatement
Section 7 General Provisions
Amendments, Endorsements, Application

Index

	Section		Section
Adjustments to Benefits	4	Part A Deductible Benefit	2
Basic Benefits	2	Payment of Claims	5
Benefit Appeals Procedure	5	Physical Examinations	5
Change of Contract	7	Premium in Default and Grace Period	6
Changes in Medicare	4	Premium Payments	6
Changes in Premium	6	Proof of Loss	5
Claim Forms	5	Reimbursement and Subrogation	5
Entire Contract	7	Reinstatement	6
Exclusions	3	Skilled Nursing Facility Benefit	2
Legal Proceedings	5	Statements in the Application	7
Maintenance of Solvency	7	Suspension of Benefits and Premiums	7
Medicare Out-of-Pocket Expense Limit	2	Termination	7
Membership	7	Time Limit on Certain Defenses	7
Notice of Claim	5	Time of Payment of Claims	5

Contract Schedule

Telephone [(800) 847-4836]

	ANNUAL PREMIUM#
BASIC BENEFIT MEDICARE SUPPLEMENT INSURANCE - PLAN L	[\$X,XXX.00]
RISK CLASS: [STANDARD NON-TOBACCO]	
TOTAL ANNUAL PREMIUM	[\$X,XXX.00]
INTERVAL OF PAYMENT	[ANNUAL]
INITIAL PREMIUM	[\$X,XXX.00]

PREMIUMS ARE SUBJECT TO CHANGE ON EACH CONTRACT ANNIVERSARY. WE EXPECT PREMIUMS TO INCREASE AS MEDICARE BENEFITS CHANGE AND AS HEALTH CARE COSTS INCREASE. PREMIUMS DEPEND ON YOUR PLACE OF RESIDENCE.

INSURED: [JOHN DOE]

AGE: [65] SEX: [MALE]

CONTRACT NUMBER: [H0012345]

DATE OF ISSUE: [JUNE 1, 2010]

1. DEFINITIONS

Application. The application(s) and all application supplements and amendments to the Application.

Calendar Year. The period beginning on each January 1 and ending the following December 31.

Coinsurance. The percentage of Medicare Eligible Expenses you must pay after Medicare payments begin. Coinsurance does not include any Deductibles. Coinsurance percentages are set by Medicare.

Copayment. The fixed amount of Medicare Eligible Expenses you must pay after Medicare payments begin. Copayment amounts do not include any Deductibles. Copayment amounts are set each year by Medicare.

Contract Anniversary. The same month and day for years after issue as in the Date of Issue on page 3.

Deductible. A fixed amount of Medicare Eligible Expenses that is not paid by Medicare. The Part A Deductible applies to the first 60 days of Hospital confinement in each Medicare Benefit Period. The Part B Deductible applies to each Calendar Year. Deductible amounts are set each year by Medicare.

Doctor. A legally qualified and licensed practitioner of the healing arts who is practicing within the scope of his authority.

Explanation of Medicare Benefits Form. The statement supplied to you by Medicare that shows the action taken on your Medicare claim.

Hospital. A legally operated facility that is approved or is eligible to be approved for payment of Medicare benefits for hospitalization, and that:

- 1) Is accredited as a hospital by the Joint Commission on Accreditation of Hospitals; or
- 2) Provides
 - a) Either on its premises or in facilities available on a prearranged basis, medical, diagnostic and major surgical facilities under the supervision of a staff of one or more Doctors for the care and treatment of sick or injured patients on an inpatient basis; and
 - b) 24-hour nursing service.

Injury. Accidental bodily injury sustained while this contract is in force.

Issue Age. Your age on the Date of Issue of this contract.

Medicaid. The Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

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

Medicare Benefit Period. The period as determined by Medicare that begins the day you are admitted to a Hospital. It ends when you have been in neither a Hospital nor a Skilled Nursing Facility for at least 60 consecutive days.

Medicare Eligible Expenses. Expenses approved by Medicare as eligible for payment under Medicare.

Medicare Lifetime Reserve Days. Extra days of Hospital coverage provided under Medicare Part A and Part B. You may use this coverage after the first 90 days of Hospital coverage during a Medicare Benefit Period.

Medicare Part A. Part A of Medicare, also known as Medicare Hospital Insurance.

Medicare Part B. Part B of Medicare, also known as Medicare Supplementary Medical Insurance.

Service Center. The location where this contract is administered. The Service Center address is shown on page 3.

Sickness. Illness or disease that first manifests itself while the contract is in force.

Skilled Nursing Facility. A legally operated facility or that part of one that is approved or eligible to be approved for payment of Medicare benefits for skilled nursing facility care.

we, our, us, Society. Thrivent Financial for Lutherans.

Written Notice. A written request or notice signed by you and received in good order by us at our Service Center.

you, your, yours. The insured.

2. BENEFITS

CORE BENEFITS

2.1 BASIC BENEFITS. For Medicare Eligible Expenses you incur for treatment of Sickness or Injury, we will pay:

- 1) Medicare Part A expenses for hospitalization that are not covered by Medicare from the 61st day through the 90th day of confinement in a Medicare Benefit Period.
- 2) Medicare Part A expenses for hospitalization that are not covered by Medicare for each day that you use one of your Medicare Lifetime Reserve days.
- 3) If you are confined for more than 90 days and you have used all of your Medicare Lifetime Reserve Days, all Medicare Part A expenses for hospitalization, subject to a lifetime maximum benefit of an additional 365 days. Benefits will be paid at the applicable prospective payment system rate or other appropriate Medicare standard of payment.
- 4) 75% of expenses for the first 3 pints of blood you receive in any Calendar Year under Medicare Parts A and B (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations. If these expenses are incurred after you have met the Medicare Out-of-Pocket Expense Limit for that year (see Section 2.5), the percentage we will pay for the rest of that Calendar Year is 100%.
- 5) 75% of Coinsurance or Copayments for Medicare Part B expenses in any Calendar Year in excess of the Part B Deductible amount, except that this percentage will be 100% for Medicare Part B preventive services. If these expenses are incurred after you have met the Medicare Out-of-Pocket Expense Limit for that year, the percentage we will pay for the rest of that Calendar Year is 100%.

ADDITIONAL BENEFITS

2.2 PART A DEDUCTIBLE BENEFIT. For each Medicare Benefit Period that you are confined in a Hospital as a result of Sickness or Injury, we will pay 75% of the Part A Deductible amount or, if less, the amount of Medicare Part A expenses that you incur. If these expenses are incurred in a Calendar Year after you have met the Medicare Out-of-Pocket Expense Limit for that year, the percentage we will pay for the rest of that Calendar Year is 100%.

2.3 SKILLED NURSING FACILITY BENEFIT. For each Medicare Benefit Period that you are confined in a Skilled Nursing Facility for post-Hospital care as a result of Sickness or Injury, we will pay 75% of the Copayment amount for the 21st through the 100th day of confinement provided that:

- 1) You were confined in a Hospital for at least 3 days; and
- 2) Confinement in a Skilled Nursing Facility began within 30 days after your Hospital confinement ended.

If these expenses are incurred in a Calendar Year after you have met the Medicare Out-of-Pocket Expense Limit for that year, the percentage we will pay for the rest of that Calendar Year is 100%.

2.4 HOSPICE CARE BENEFIT. For each Medicare Benefit Period that you are confined in a hospice as a result of Sickness or Injury, we will pay you 75% of the Copayment amount for Medicare Eligible Expenses and respite care. If these expenses are incurred in a Calendar Year after you have met the Medicare Out-of-Pocket Expense Limit for that year, the percentage we will pay for the rest of that Calendar Year is 100%.

2.5 MEDICARE OUT-OF-POCKET EXPENSE LIMIT. The Medicare Out-of-Pocket Expense Limit is the maximum amount that you must pay in a Calendar Year for Medicare Deductibles, Coinsurance and Copayments. You meet this limit for a Calendar Year when amounts that you have paid in that year for these expenses equal or exceed the Medicare Out-of-Pocket Expense Limit. After you meet this limit in any year, we will pay 100% of all Medicare Eligible Expenses covered by this contract for the rest of that Calendar Year. The Medicare Out-Of-Pocket Expense Limit is set each year by Medicare.

3. EXCLUSIONS

3.1 EXCLUSIONS. This contract covers only those expenses that are approved for payment by Medicare.

This contract does not cover expenses due to:

- 1) Care, treatment or supplies to the extent that you are entitled to have payment made under:
 - a) Medicare or any other governmental program (except Medicaid);

- b) Any other Medicare Supplement Insurance contract; or
- c) Any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law;
- 2) Services for which no charge is normally made in the absence of insurance; or
- 3) Items or services for which you have no legal obligation to pay.

4. ADJUSTMENTS TO BENEFITS

4.1 ADJUSTMENTS TO BENEFITS. At the beginning of each Calendar Year, we will adjust your benefits to reflect any changes in the Part A Deductible, Copayment amounts or the Part B Deductible. If an adjustment results in a change in premium, the new premium will be effective on the first Contract Anniversary after the adjustment in benefits. We will give you at least 30 days notice of any increase in premium.

4.2 CHANGES IN MEDICARE. Changes in Medicare, other than as in Section 4.1, that affect the coverage provided by this contract may require an adjustment in benefits and premiums.

5. CLAIMS

5.1 NOTICE OF CLAIM. A notice of claim must be given to us at our Service Center within 30 days after a covered loss starts or as soon after this as reasonably possible. Notice should include your name and contract number.

5.2 CLAIM FORMS. When we receive your notice of claim, we will send you information for filing proof of loss. If we do not send this information within 15 days, you may meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in Section 5.3.

5.3 PROOF OF LOSS. Proof of loss must be given to us at our Service Center. This should be done within 90 days after the loss occurs. Failure to give proof within 90 days will not affect the claim if proof is given as soon as is reasonably possible, but the proof must be given no later than one year from the time proof is otherwise required, unless you were legally incapacitated.

Before filing a claim for Part B Medicare Eligible Expenses under this contract, you must first file your claim with Medicare. Send us the Explanation of Medicare Benefits form that you receive from Medicare and the itemized bills from your health care providers. On dually assigned claims submitted by participating Doctors and suppliers, we will accept notice from the Medicare carriers as a claim for benefits in place of any other claim form otherwise required and we will make a payment determination based on the information contained in that notice.

5.4 TIME OF PAYMENT OF CLAIMS. We will pay benefits for losses covered under this contract as soon as we receive sufficient proof of loss.

5.5 PAYMENT OF CLAIMS. Benefits will be paid to you or to your health care provider to whom you have assigned benefits. Any benefits payable to you that are unpaid at your death will be paid to your estate.

5.6 PHYSICAL EXAMINATIONS. In addition to other proof of loss, we may require you to have physical examinations as often as reasonably necessary while a claim is pending or being paid. It will be at our expense.

5.7 BENEFIT APPEALS PROCEDURE. If you have a claim for benefits that is denied in whole or in part, you may appeal the claim denial by sending us a written request for review. Mail this request to our Service Center and enclose any information that you think will help us review your claim. Within 30 days after we receive your request, we will review your claim in detail and send you written notification of the results of the review.

5.8 LEGAL PROCEEDINGS. No legal proceeding to recover on this contract may be commenced until at least 60 days after written proof of loss has been given. No such proceeding may be commenced after 3 years from the time written proof of loss is required to be given.

5.9 REIMBURSEMENT AND SUBROGATION. If we pay any benefits for any expenses you incur due to any act of a third party who is or may become liable to you because of that act, then we are entitled to subrogation from the third party. If you recover from a third party, the reasonable costs of collection and attorney fees will be assessed against you and us in the proportion that each benefits from recovery.

You must provide us with timely written notice of any claim you make against a third party for payment or reimbursement of medical and medically-related expenses. At our option, we may take any action we deem appropriate to protect our rights under this reimbursement and subrogation provision including, without limitation, seeking to intervene in any lawsuit or other proceeding you have begun against a third party. The statute of limitations applicable to our right to seek reimbursement or subrogation does not begin to run until you have given us written notice.

6. PREMIUMS AND REINSTATEMENT

6.1 PREMIUM PAYMENTS. The Initial Premium amount and its Interval of Payment are shown on page 3. The Initial Premium is due and payable on the Date of Issue. Each subsequent premium is due on the first day of its Interval of Payment.

Premiums are payable at our Service Center. Upon request, we will give you a receipt, signed by an officer of the Society, for premium paid.

6.2 PREMIUM BILLING. We will send premium billings based upon the Interval of Payment that you request. Subject to our published rules, you may change the Interval of Payment or the method of billing by giving Written Notice.

6.3 CHANGES IN PREMIUM. We may change our table of premiums on any Contract Anniversary. Any change will apply to all like contracts in force in your state of residence. We will not change your premium because of a change in your health. If your premium changes because of a change in your place of residence, the new premium will be effective on the next premium due date after your change of residence. We will give you at least 30 days notice of any increase in premium.

6.4 PREMIUM IN DEFAULT AND GRACE PERIOD. Any premium not paid on or before the date it is due is a premium in default. Except for the Initial Premium, you may pay the premium in default within a grace period of 31 days after the date it is due. During the grace period, this contract will remain in force. If the premium in default is not paid within the grace period, this contract will terminate at the end of the grace period.

6.5 REINSTATEMENT. If this contract terminates as in Section 6.4, you must pay any premium in default to reinstate it. The contract is reinstated when we accept the payment, unless we also require an application for reinstatement.

If we require an application for reinstatement, we must give you notice of approval or disapproval within 45 days after the date of the application. We will reinstate the contract as soon as it is approved. If we do not notify you within this 45-day period, the contract will automatically be reinstated on the 45th day.

The reinstated contract will cover only losses that result from:

- 1) Injury sustained after the date of reinstatement; or
- 2) Sickness that first manifests itself after the date of reinstatement.

All other rights that you or we had immediately before the default in premium payments again apply, subject to any provisions endorsed on or attached to this contract when it is reinstated.

Section 7.4 Time Limit on Certain Defenses will apply from the date the contract is reinstated with regard to statements made in the application for reinstatement.

This contract cannot be reinstated after 5 months from the end of the grace period.

7. GENERAL PROVISIONS

7.1 ENTIRE CONTRACT. The Entire Contract consists of:

- 1) This contract including any attached riders, amendments or endorsements;
- 2) The Application attached to this contract; and
- 3) The Articles of Incorporation and Bylaws of the Society and all amendments to them.

Benefits will not be reduced by any future amendments to our Articles of Incorporation or Bylaws.

7.2 CHANGE OF CONTRACT. No change to this contract is valid unless it is made in writing and signed by our President or Secretary.

7.3 STATEMENTS IN THE APPLICATION. We will not use any statements to contest a claim or to have this contract declared invalid unless the statement is contained in the Application. All statements made in the Application are considered representations, not warranties.

7.4 TIME LIMIT ON CERTAIN DEFENSES.

- 1) **Misstatements in the Application.** After this contract has been in force during your lifetime for two years from the Date of Issue, no statement made in the Application, except fraudulent misrepresentation, shall be used to void this contract or deny a claim for loss incurred or disability that begins after the end of the two-year period.
- 2) **Pre-Existing Conditions.** No claim for loss incurred after the Date of Issue will be reduced or denied because a disease or physical condition existed before the Date of Issue.

This provision will apply from the date this contract is reinstated with regard to statements made in the application for reinstatement.

7.5 MAINTENANCE OF SOLVENCY. If the solvency of the Society becomes impaired, you may be required to make an extra payment. The Board of Directors will determine the amount of any extra payment. It will be based on each member's fair share of the deficiency.

7.6 MEMBERSHIP. You are a member of the Society. Rights and privileges of membership are set forth in the Articles of Incorporation and Bylaws of the Society. These rights and privileges are separate from ownership of this contract.

7.7 CONFORMITY WITH STATE STATUTES. On the Date of Issue, any provision of this contract in conflict with the laws of the state in which you reside on that date is amended to conform with those state laws.

7. GENERAL PROVISIONS**(continued)****7.8 SUSPENSION OF BENEFITS AND PREMIUMS.**

- 1) **Suspension for Medicaid Eligibility.** If you are determined to be entitled to Medicaid, you may request to have this contract suspended for 24 months or, if earlier, until your entitlement to Medicaid ends. To suspend this contract, you must give us Written Notice within 90 days after entitlement for Medicaid begins.

If your entitlement ends and you give us Written Notice of that within 90 days after entitlement ends, we will reinstate your contract as of the date your entitlement ended. You must pay any premium due from the date entitlement ended. The reinstated contract will be the same as if no suspension had occurred.

- 2) **Suspension for Coverage under Social Security Act Section 226(b).** If you are disabled before age 65, entitled to disability benefits under Section 226(b) of the Social Security Act and covered under a group health plan as defined in the Social Security Act, you may request to have this contract suspended by giving us Written Notice.

If your coverage under the group health plan is terminated after this contract is suspended and you give us Written Notice of that within 90 days after termination, we will reinstate your contract as of the date of termination. You must pay any premium due from the date of termination of the group health coverage. The reinstated contract will be the same as if no suspension had occurred.

7.9 DIVIDENDS. Each year we will determine our divisible surplus. This contract's share, if any, will be credited as a dividend on the Contract Anniversary and paid to you in cash. Since we do not expect this contract to contribute to divisible surplus, it is not expected that any dividends will be credited.

7.10 TERMINATION. This contract will terminate at the earliest of the following dates:

- 1) The end of the grace period if any premium is then in default (see Section 6.4).
- 2) The date of your Written Notice to cancel this contract. The date of Written Notice is the date we receive it or, if later, the date you specify.
- 3) The date of death of the insured.

If this contract terminates, benefits for continuous losses that began while the contract was in force will continue while you are continuously totally disabled, as defined by the Social Security Act, but not beyond the end of the Medicare Benefit Period or the Calendar Year for which benefits would otherwise be payable under this contract. We will refund the portion of any premium paid for the period beyond the date of termination.

Medicare supplement insurance.
Guaranteed renewable for life.
Premiums expected to increase.

This certificate of membership and Medicare supplement insurance is a legal contract between you and Thrivent Financial for Lutherans. We issue this contract based on the signed Application and payment of the Initial Premium shown on page 3. We will pay benefits according to the provisions of this contract. Coverage begins at 12:01 a.m. on the Date of Issue or, if later, the date we receive the Initial Premium for this contract. It ends at 11:59 p.m. on the day this contract terminates (see Section 7.11).

This contract is guaranteed renewable for life. You may keep this contract in force, regardless of any change in health, by paying premiums when due. We cannot cancel this contract or reduce benefits other than as provided in Section 4.

Table of Premiums - Premiums May Change. The Initial Premium is shown on page 3. It applies to the first year of coverage. Renewal premiums will be charged according to our table of premiums in effect on each Contract Anniversary. We expect premiums to increase as Medicare benefits change and as health care costs increase. Premiums also depend on your place of residence. Any change in premiums will apply on a class basis to all contracts in force on this form in your state of residence. We will not change your premium due to changes in your health or due to any claims on this contract.

Notice to Buyer: This contract may not cover all of your medical expenses.

Right to Cancel. Please read this contract carefully. You may cancel the contract for any reason before midnight of the 30th day after you first receive it. Do this by (1) mailing or delivering Written Notice to our Service Center and (2) returning the contract. Notice given by mail and return of the contract by mail are effective on being postmarked, properly addressed and postage prepaid. If you cancel the contract, it will be deemed void from the beginning and we will refund any premium paid.

Important Notice - Statements in the Application. Please read the copy of the Application attached to this contract. This contract was issued on the basis that all information shown in the Application is correct and complete. Omissions or misstatements in the application could cause a claim to be denied or make this contract void. If any information shown is not correct or complete or if any past medical history has been left out of the Application, contact us immediately.

Caution: Except as provided in Section 2.4 Foreign Travel Emergency Benefit, this contract covers only those expenses that are approved for payment by Medicare.

Medicare supplement insurance.
Guaranteed renewable for life.
Premiums expected to increase.

Signed for the Society

President []

Secretary []

INSURED: [JOHN DOE]

AGE: [65] SEX: [MALE]

CONTRACT NUMBER: [H0012345]

DATE OF ISSUE: [JUNE 1, 2010]

Table of Contents

Cover Page
Index
Contract Schedule, Contract Data
Section 1 Definitions
Section 2 Benefits
Section 3 Exclusions
Section 4 Adjustments to Benefits
Section 5 Claims
Section 6 Premiums and Reinstatement
Section 7 General Provisions
Amendments, Endorsements, Application

Index

	Section		Section
Adjustments to Benefits	4	Part A Deductible Benefit	2
Basic Benefits	2	Payment of Claims	5
Benefit Appeals Procedure	5	Physical Examinations	5
Change of Contract	7	Premium in Default and Grace Period	6
Changes in Medicare	4	Premium Payments	6
Changes in Premium	6	Proof of Loss	5
Claim Forms	5	Reimbursement and Subrogation	5
Entire Contract	7	Reinstatement	6
Exclusions	3	Skilled Nursing Facility Benefit	2
Foreign Travel Emergency Benefit	2	Statements in the Application	7
Legal Proceedings	5	Suspension of Benefits and Premiums	7
Maintenance of Solvency	7	Termination	7
Membership	7	Time Limit on Certain Defenses	7
Notice of Claim	5	Time of Payment of Claims	5

Contract Schedule

Telephone [(800) 847-4836]

	ANNUAL PREMIUM#
BASIC BENEFIT	
MEDICARE SUPPLEMENT INSURANCE - PLAN M	[&#AAMT.]
RISK CLASS: [STANDARD NON-TOBACCO]	
	TOTAL ANNUAL PREMIUM [\$X,XXX.00]
	INTERVAL OF PAYMENT [ANNUAL]
	INITIAL PREMIUM [&#MPRM.]

PREMIUMS ARE SUBJECT TO CHANGE ON EACH CONTRACT ANNIVERSARY. WE EXPECT PREMIUMS TO INCREASE AS MEDICARE BENEFITS CHANGE AND AS HEALTH CARE COSTS INCREASE. PREMIUMS DEPEND ON YOUR PLACE OF RESIDENCE.

INSURED: [JOHN DOE]

AGE: [65] SEX: [MALE]

CONTRACT NUMBER: [H0012345]

DATE OF ISSUE: [JUNE 1, 2010]

1. DEFINITIONS

Application. The application(s) and all application supplements and amendments to the Application.

Calendar Year. The period beginning on each January 1 and ending the following December 31.

Coinsurance. The percentage of Medicare Eligible Expenses you must pay after Medicare payments begin. Coinsurance does not include any Deductibles. Coinsurance percentages are set by Medicare.

Copayment. The fixed amount of Medicare Eligible Expenses you must pay after Medicare payments begin. Copayment amounts do not include any Deductibles. Copayment amounts are set each year by Medicare.

Contract Anniversary. The same month and day for years after issue as in the Date of Issue on page 3.

Deductible. A fixed amount of Medicare Eligible Expenses that is not paid by Medicare. The Part A Deductible applies to the first 60 days of Hospital confinement in each Medicare Benefit Period. The Part B Deductible applies to each Calendar Year. Deductible amounts are set each year by Medicare.

Doctor. A legally qualified and licensed practitioner of the healing arts who is practicing within the scope of his authority.

Explanation of Medicare Benefits Form. The statement supplied to you by Medicare that shows the action taken on your Medicare claim.

Hospital. A legally operated facility that is approved or is eligible to be approved for payment of Medicare benefits for hospitalization, and that:

- 1) Is accredited as a hospital by the Joint Commission on Accreditation of Hospitals; or
- 2) Provides
 - a) Either on its premises or in facilities available on a prearranged basis, medical, diagnostic and major surgical facilities under the supervision of a staff of one or more Doctors for the care and treatment of sick or injured patients on an inpatient basis; and
 - b) 24-hour nursing service.

Injury. Accidental bodily injury sustained while this contract is in force.

Issue Age. Your age on the Date of Issue of this contract.

Medicaid. The Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

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

Medicare Benefit Period. The period as determined by Medicare that begins the day you are admitted to a Hospital. It ends when you have been in neither a Hospital nor a Skilled Nursing Facility for at least 60 consecutive days.

Medicare Eligible Expenses. Expenses approved by Medicare as eligible for payment under Medicare.

Medicare Lifetime Reserve Days. Extra days of Hospital coverage provided under Medicare Part A and Part B. You may use this coverage after the first 90 days of Hospital coverage during a Medicare Benefit Period.

Medicare Part A. Part A of Medicare, also known as Medicare Hospital Insurance.

Medicare Part B. Part B of Medicare, also known as Medicare Supplementary Medical Insurance.

Service Center. The location where this contract is administered. The Service Center address is shown on page 3.

Sickness. Illness or disease that first manifests itself while the contract is in force.

Skilled Nursing Facility. A legally operated facility or that part of one that is approved or eligible to be approved for payment of Medicare benefits for skilled nursing facility care.

we, our, us, Society. Thrivent Financial for Lutherans.

Written Notice. A written request or notice signed by you and received in good order by us at our Service Center.

you, your, yours. The insured.

2. BENEFITS

CORE BENEFITS

2.1 BASIC BENEFITS. For Medicare Eligible Expenses you incur for treatment of Sickness or Injury, we will pay:

- 1) Medicare Part A expenses for hospitalization that are not covered by Medicare from the 61st day through the 90th day of confinement in a Medicare Benefit Period.
- 2) Medicare Part A expenses for hospitalization that are not covered by Medicare for each day that you use one of your Medicare Lifetime Reserve days.
- 3) If you are confined for more than 90 days and you have used all of your Medicare Lifetime Reserve Days, all Medicare Part A expenses for hospitalization, subject to a lifetime maximum benefit of an additional 365 days. Benefits will be paid at the applicable prospective payment system rate or other appropriate Medicare standard of payment.
- 4) Medicare Part A expenses for hospice and respite care that are not covered by Medicare.
- 5) Expenses for the first 3 pints of blood you receive under Medicare Parts A and B (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.
- 6) The Coinsurance portion of Medicare Part B expenses in any Calendar Year in excess of the Part B Deductible amount. For Hospital outpatient expenses paid under a prospective payment system, we will pay the Copayment amount.

ADDITIONAL BENEFITS

2.2 PART A DEDUCTIBLE BENEFIT. For each Medicare Benefit Period that you are confined in a Hospital as a result of Sickness or Injury, we will pay 50% of the Part A Deductible amount or, if less, the amount of Medicare Part A expenses that you incur.

2.3 SKILLED NURSING FACILITY BENEFIT. For each Medicare Benefit Period that you are confined in a Skilled Nursing Facility for post-Hospital care as a result of Sickness or Injury, we will pay the Copayment amount for the 21st through the 100th day of confinement provided that:

- 1) You were confined in a Hospital for at least 3 days; and
- 2) Confinement in a Skilled Nursing Facility began within 30 days after your Hospital confinement ended.

2.4 FOREIGN TRAVEL EMERGENCY BENEFIT. For each Calendar Year in which you travel outside the United States and receive medically necessary emergency hospital, physician or medical care in a foreign country, we will pay 80% of the billed charges in excess of a \$250 annual deductible for expenses that you incur for that care. Total benefits paid under this provision will not exceed \$50,000 for your lifetime.

For purposes of this provision:

- 1) Emergency care is care that is needed immediately as a result of an Injury or Sickness of sudden and unexpected onset. Benefits are payable only if:
 - a) The care would have been covered by Medicare had it been received in the United States; and
 - b) For each trip you make outside the United States, the care begins within 60 days of the day you left the United States.
- 2) Medically necessary care is care and treatment that is reasonable and appropriate for the diagnosis, care and treatment of your Sickness or Injury.
- 3) Physician does not include you or a member of your family.

3. EXCLUSIONS

3.1 EXCLUSIONS. Except as provided in Section 2.4 Foreign Travel Emergency Benefit, this contract covers only those expenses that are approved for payment by Medicare.

This contract does not cover expenses due to:

- 1) Care, treatment or supplies to the extent that you are entitled to have payment made under:
 - a) Medicare or any other governmental program (except Medicaid);

- b) Any other Medicare Supplement Insurance contract; or
- c) Any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law;
- 2) Services for which no charge is normally made in the absence of insurance; or
- 3) Items or services for which you have no legal obligation to pay.

4. ADJUSTMENTS TO BENEFITS

4.1 ADJUSTMENTS TO BENEFITS. At the beginning of each Calendar Year, we will adjust your benefits to reflect any changes in the Part A Deductible, Copayment amounts or the Part B Deductible. If an adjustment results in a change in premium, the new premium will be effective on the first Contract Anniversary after the adjustment in benefits. We will give you at least 30 days notice of any increase in premium.

4.2 CHANGES IN MEDICARE. Changes in Medicare, other than as in Section 4.1, that affect the coverage provided by this contract may require an adjustment in benefits and premiums.

5. CLAIMS

5.1 NOTICE OF CLAIM. A notice of claim must be given to us at our Service Center within 30 days after a covered loss starts or as soon after this as reasonably possible. Notice should include your name and contract number.

5.2 CLAIM FORMS. When we receive your notice of claim, we will send you information for filing proof of loss. If we do not send this information within 15 days, you may meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in Section 5.3.

5.3 PROOF OF LOSS. Proof of loss must be given to us at our Service Center. This should be done within 90 days after the loss occurs. Failure to give proof within 90 days will not affect the claim if proof is given as soon as is reasonably possible, but the proof must be given no later than one year from the time proof is otherwise required, unless you were legally incapacitated.

Before filing a claim for Part B Medicare Eligible Expenses under this contract, you must first file your claim with Medicare. Send us the Explanation of Medicare Benefits form that you receive from Medicare and the itemized bills from your health care providers. On dually assigned claims submitted by participating Doctors and suppliers, we will accept notice from the Medicare carriers as a claim for benefits in place of any other claim form otherwise required and we will make a payment determination based on the information contained in that notice.

5.4 TIME OF PAYMENT OF CLAIMS. We will pay benefits for losses covered under this contract as soon as we receive sufficient proof of loss.

5.5 PAYMENT OF CLAIMS. Benefits will be paid to you or to your health care provider to whom you have assigned benefits. Any benefits payable to you that are unpaid at your death will be paid to your estate.

5.6 PHYSICAL EXAMINATIONS. In addition to other proof of loss, we may require you to have physical examinations as often as reasonably necessary while a claim is pending or being paid. It will be at our expense.

5.7 BENEFIT APPEALS PROCEDURE. If you have a claim for benefits that is denied in whole or in part, you may appeal the claim denial by sending us a written request for review. Mail this request to our Service Center and enclose any information that you think will help us review your claim. Within 30 days after we receive your request, we will review your claim in detail and send you written notification of the results of the review.

5.8 LEGAL PROCEEDINGS. No legal proceeding to recover on this contract may be commenced until at least 60 days after written proof of loss has been given. No such proceeding may be commenced after 3 years from the time written proof of loss is required to be given.

5.9 REIMBURSEMENT AND SUBROGATION. If we pay any benefits for any expenses you incur due to any act of a third party who is or may become liable to you because of that act, then we are entitled to subrogation from the third party. If you recover from a third party, the reasonable costs of collection and attorney fees will be assessed against you and us in the proportion that each benefits from recovery.

You must provide us with timely written notice of any claim you make against a third party for payment or reimbursement of medical and medically-related expenses. At our option, we may take any action we deem appropriate to protect our rights under this reimbursement and subrogation provision including, without limitation, seeking to intervene in any lawsuit or other proceeding you have begun against a third party. The statute of limitations applicable to our right to seek reimbursement or subrogation does not begin to run until you have given us written notice.

6. PREMIUMS AND REINSTATEMENT

6.1 PREMIUM PAYMENTS. The Initial Premium amount and its Interval of Payment are shown on page 3. The Initial Premium is due and payable on the Date of Issue. Each subsequent premium is due on the first day of its Interval of Payment.

Premiums are payable at our Service Center. Upon request, we will give you a receipt, signed by an officer of the Society, for premium paid.

6.2 PREMIUM BILLING. We will send premium billings based upon the Interval of Payment that you request. Subject to our published rules, you may change the Interval of Payment or the method of billing by giving Written Notice.

6.3 CHANGES IN PREMIUM. We may change our table of premiums on any Contract Anniversary. Any change will apply to all like contracts in force in your state of residence. We will not change your premium because of a change in your health. If your premium changes because of a change in your place of residence, the new premium will be effective on the next premium due date after your change of residence. We will give you at least 30 days notice of any increase in premium.

6.4 PREMIUM IN DEFAULT AND GRACE PERIOD. Any premium not paid on or before the date it is due is a premium in default. Except for the Initial Premium, you may pay the premium in default within a grace period of 31 days after the date it is due. During the grace period, this contract will remain in force. If the premium in default is not paid within the grace period, this contract will terminate at the end of the grace period.

6.5 REINSTATEMENT. If this contract terminates as in Section 6.4, you must pay any premium in default to reinstate it. The contract is reinstated when we accept the payment, unless we also require an application for reinstatement.

If we require an application for reinstatement, we must give you notice of approval or disapproval within 45 days after the date of the application. We will reinstate the contract as soon as it is approved. If we do not notify you within this 45-day period, the contract will automatically be reinstated on the 45th day.

The reinstated contract will cover only losses that result from:

- 1) Injury sustained after the date of reinstatement; or
- 2) Sickness that first manifests itself after the date of reinstatement.

All other rights that you or we had immediately before the default in premium payments again apply, subject to any provisions endorsed on or attached to this contract when it is reinstated.

Section 7.4 Time Limit on Certain Defenses will apply from the date the contract is reinstated with regard to statements made in the application for reinstatement.

This contract cannot be reinstated after 5 months from the end of the grace period.

7. GENERAL PROVISIONS

7.1 ENTIRE CONTRACT. The Entire Contract consists of:

- 1) This contract including any attached riders, amendments or endorsements;
- 2) The Application attached to this contract; and
- 3) The Articles of Incorporation and Bylaws of the Society and all amendments to them.

Benefits will not be reduced by any future amendments to our Articles of Incorporation or Bylaws.

7.2 CHANGE OF CONTRACT. No change to this contract is valid unless it is made in writing and signed by our President or Secretary.

7.3 STATEMENTS IN THE APPLICATION. We will not use any statements to contest a claim or to have this contract declared invalid unless the statement is contained in the Application. All statements made in the Application are considered representations, not warranties.

7.4 TIME LIMIT ON CERTAIN DEFENSES.

- 1) **Misstatements in the Application.** After this contract has been in force during your lifetime for two years from the Date of Issue, no statement made in the Application, except fraudulent misrepresentation, shall be used to void this contract or deny a claim for loss incurred or disability that begins after the end of the two-year period.
- 2) **Pre-Existing Conditions.** No claim for loss incurred after the Date of Issue will be reduced or denied because a disease or physical condition existed before the Date of Issue.

This provision will apply from the date this contract is reinstated with regard to statements made in the application for reinstatement.

7.5 MAINTENANCE OF SOLVENCY. If the solvency of the Society becomes impaired, you may be required to make an extra payment. The Board of Directors will determine the amount of any extra payment. It will be based on each member's fair share of the deficiency.

7.6 MEMBERSHIP. You are a member of the Society. Rights and privileges of membership are set forth in the Articles of Incorporation and Bylaws of the Society. These rights and privileges are separate from ownership of this contract.

7.7 CONFORMITY WITH STATE STATUTES. On the Date of Issue, any provision of this contract in conflict with the laws of the state in which you reside on that date is amended to conform with those state laws.

7. GENERAL PROVISIONS**(continued)****7.8 SUSPENSION OF BENEFITS AND PREMIUMS.**

- 1) **Suspension for Medicaid Eligibility.** If you are determined to be entitled to Medicaid, you may request to have this contract suspended for 24 months or, if earlier, until your entitlement to Medicaid ends. To suspend this contract, you must give us Written Notice within 90 days after entitlement for Medicaid begins.

If your entitlement ends and you give us Written Notice of that within 90 days after entitlement ends, we will reinstate your contract as of the date your entitlement ended. You must pay any premium due from the date entitlement ended. The reinstated contract will be the same as if no suspension had occurred.

- 2) **Suspension for Coverage under Social Security Act Section 226(b).** If you are disabled before age 65, entitled to disability benefits under Section 226(b) of the Social Security Act and covered under a group health plan as defined in the Social Security Act, you may request to have this contract suspended by giving us Written Notice.

If your coverage under the group health plan is terminated after this contract is suspended and you give us Written Notice of that within 90 days after termination, we will reinstate your contract as of the date of termination. You must pay any premium due from the date of termination of the group health coverage. The reinstated contract will be the same as if no suspension had occurred.

7.9 DIVIDENDS. Each year we will determine our divisible surplus. This contract's share, if any, will be credited as a dividend on the Contract Anniversary and paid to you in cash. Since we do not expect this contract to contribute to divisible surplus, it is not expected that any dividends will be credited.

7.10 TERMINATION. This contract will terminate at the earliest of the following dates:

- 1) The end of the grace period if any premium is then in default (see Section 6.4).
- 2) The date of your Written Notice to cancel this contract. The date of Written Notice is the date we receive it or, if later, the date you specify.
- 3) The date of death of the insured.

If this contract terminates, benefits for continuous losses that began while the contract was in force will continue while you are continuously totally disabled, as defined by the Social Security Act, but not beyond the end of the Medicare Benefit Period or the Calendar Year for which benefits would otherwise be payable under this contract. We will refund the portion of any premium paid for the period beyond the date of termination.

Medicare supplement insurance.
Guaranteed renewable for life.
Premiums expected to increase.

New Business

 Contract Change: Contract number - _____

Section 1 - Proposed Insured

Name (print title, first, middle, last name and suffix, as applicable)

Date of birth (mm/dd/yyyy)	Sex	Age	State of residence	ZIP code
Are you enrolled or will you be enrolled in Medicare Part B in the next six months?				Medicare claim number
<input type="checkbox"/> Yes <input type="checkbox"/> No - This coverage can not be issued.				Date shown on Medicare ID card

Section 2 - Medicare and Other Coverage Information

You do not need more than one Medicare supplement contract. If you purchase this contract, you may want to evaluate your existing health coverage and decide if you need multiple coverages. You may be eligible for benefits under Medicaid and may not need a Medicare supplement contract.

If, after purchasing this contract, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement contract can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement contract (or, if that is no longer available, a substantially equivalent contract) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement contract provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your contract was suspended, the reinstated contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

If you are eligible for, and have enrolled in a Medicare supplement contract by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement contract can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement contract under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement contract (or, if this is no longer available, a substantially equivalent contract) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement contract provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your contract was suspended, the reinstated contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance contract, or that you had certain rights to buy such a contract, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application.

Yes No To the best of your knowledge:

1. Do you have another Medicare Supplement contract in force?
If Yes,
Name of company - _____
Name of plan - _____ Contract number - _____

Do you intend to replace your current Medicare supplement contract with this contract?
If Yes, submit a replacement form. If No, this coverage cannot be issued.

2. Have you had coverage under any other health insurance within the past 63 days?
(For example, an employer, union, or individual plan.)
If Yes,
Name of company - _____

Type of contract - _____ Contract number - _____

What are your dates of coverage under the other contract?

If you are still covered under the other contract, leave "End date" blank.

Start date - _____ End date - _____
(mm/dd/yyyy) (mm/dd/yyyy)

3. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days?
(For example, a Medicare Advantage plan, or a Medicare HMO or PPO.)
If Yes, fill in your start and end date. If you are still covered under this plan, leave "End date" blank.

Start date - _____ End date - _____
(mm/dd/yyyy) (mm/dd/yyyy)

Do you intend to replace your current coverage with this new Medicare supplement contract?
If Yes, submit a replacement form.

Was this your first time in this type of Medicare plan?

Did you drop a Medicare supplement contract to enroll in the Medicare plan?

4. Are you covered for medical assistance through the state Medicaid program?
Note: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer **No** to this question.

If Yes,

Will Medicaid pay your premiums for this Medicare supplement contract?

Do you receive any benefits from Medicaid **other than** payments toward your Medicare Part B premium?

Section 3 - New Business Product Information

1. Plan selected - _____

2. Requested effective date - _____
(mm/dd/yyyy)

3. Within the past 12 months, have you used tobacco or other nicotine products? Yes No

Note: Do not answer this question if in open enrollment.

Section 4 - Contract Change

Delete Part A Deductible Delete prescription drug rider Remove rating

Change to non-tobacco - Within the past 12 months, have you used tobacco or other nicotine products? Yes No

Requested effective date of change - _____
(mm/dd/yyyy)

Section 5 - Declaration of Insurability - Complete this section only when evidence of insurability is required.

1. Within the past five years, have you been diagnosed, been treated, or taken medication for:

- | | | | | | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|---|
| Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | a. Angina | <input type="checkbox"/> | <input type="checkbox"/> | u. Cirrhosis |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Heart attack | <input type="checkbox"/> | <input type="checkbox"/> | v. Crohn's disease |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Heart surgery | <input type="checkbox"/> | <input type="checkbox"/> | w. Ulcerative colitis |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Peripheral artery disease or gangrene | <input type="checkbox"/> | <input type="checkbox"/> | x. Kidney disease requiring dialysis |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Angioplasty | <input type="checkbox"/> | <input type="checkbox"/> | y. Kidney failure |
| <input type="checkbox"/> | <input type="checkbox"/> | f. Stroke | <input type="checkbox"/> | <input type="checkbox"/> | z. Insulin dependent diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | g. Congestive heart failure | <input type="checkbox"/> | <input type="checkbox"/> | aa. Amyotrophic lateral sclerosis
(Lou Gehrig's disease) |
| <input type="checkbox"/> | <input type="checkbox"/> | h. Atrial fibrillation | <input type="checkbox"/> | <input type="checkbox"/> | bb. Alzheimer's disease or other dementia |
| <input type="checkbox"/> | <input type="checkbox"/> | i. Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | cc. Parkinson's disease |
| <input type="checkbox"/> | <input type="checkbox"/> | j. Carotid or femoral artery surgery | <input type="checkbox"/> | <input type="checkbox"/> | dd. Multiple sclerosis |
| <input type="checkbox"/> | <input type="checkbox"/> | k. Cardiomyopathy | <input type="checkbox"/> | <input type="checkbox"/> | ee. Rheumatoid arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | l. Aneurysm | <input type="checkbox"/> | <input type="checkbox"/> | ff. Systemic lupus erythematosus |
| <input type="checkbox"/> | <input type="checkbox"/> | m. Transient Ischemic Attack (TIA) | <input type="checkbox"/> | <input type="checkbox"/> | gg. Schizophrenia |
| <input type="checkbox"/> | <input type="checkbox"/> | n. Internal cancer | <input type="checkbox"/> | <input type="checkbox"/> | hh. Bipolar or manic depression |
| <input type="checkbox"/> | <input type="checkbox"/> | o. Melanoma | <input type="checkbox"/> | <input type="checkbox"/> | ii. Alcohol or drug abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | p. Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | jj. Acquired Immune Deficiency Syndrome
(AIDS) or AIDS related complex |
| <input type="checkbox"/> | <input type="checkbox"/> | q. Lymphoma | <input type="checkbox"/> | <input type="checkbox"/> | kk. Organ transplant (other than corneal) |
| <input type="checkbox"/> | <input type="checkbox"/> | r. Emphysema | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | s. Chronic lung disease | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | t. Pancreatitis | | | |
2. Within the past two years, have you been advised to have surgery or other test(s) not yet completed?
3. Have you been confined in a hospital or nursing facility or has confinement to a hospital or nursing facility been recommended to you in the last six months?
4. Have you been confined in a hospital or nursing facility three or more times in the past two years?
5. Are you currently bedridden or using a wheelchair, walker, chairlift, or oxygen?

If there are any 'Yes' answers to questions 1 through 5, do not proceed with completing this application as coverage will not be issued. No other sources of information will be reviewed. It is the responsibility of the proposed insured to provide the correct responses to the questions in the application.

Section 6 - Premium Payment Information

(Premium must be submitted with application if proposed insured is 64 years and 10 months or older.)

Total initial premium	Frequency of initial premium:
\$	<input type="checkbox"/> Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly

Section 7 - Third Party Notification

I understand I have the right to designate at least one person other than myself to receive notice of cancellation of this insurance contract or rider for nonpayment of premium. I understand that notice to my designee will be given at least 10 days prior to the effective date of cancellation of my contract. I request you notify the following person:

I elect not to designate any person to receive such notice.

Name (print title, first, middle, last name and suffix, as applicable)

Address	City
	State ZIP code Phone

Benefit Chart of Medicare Supplement Plans Sold with an Effective Date of Coverage on or After June 1, 2010

Plans A, B, C, D, F, high deductible F, G, L, M

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan “A” available. Some plans may not be available in your state.

Plans E, H, I, and J are no longer available for sale.

Basic Benefits:

- **Hospitalization** – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** – First three pints of blood each year.
- **Hospice** – Part A coinsurance.

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

***Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2000] deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed [\$2000]. 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 plan’s separate foreign travel emergency deductible.**

Shaded plans represent those offered by Thrivent Financial for Lutherans.

Benefit Chart of Medicare Supplement Plans Sold with an Effective Date of Coverage on or After June 1, 2010

Plans A, B, C, D, F, high deductible F, G, L, M

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan “A” available. Some plans may not be available in your state.

Plans E, H, I, and J are no longer available for sale.

Basic Benefits:

- **Hospitalization** – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** – First three pints of blood each year.
- **Hospice** – Part A coinsurance.

K	L	M	N
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
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit \$[4620]; paid at 100% after limit reached	Out-of-pocket limit \$[2310]; paid at 100% after limit reached		

Shaded plans represent those offered by Thrivent Financial for Lutherans.

Non-Smoker – Community Rated – ZIP 722

Chart shows \$ amount for all ages.

	Mode	Plan A	Plan B	Plan C	Plan D	Plan F	Plan F*	Plan G	Plan L	Plan M
All Ages	Annual	1,480.00	1,872.00	2,475.00	2,104.00	2,484.00	812.00	2,128.00	1,498.00	1,935.00
All Ages	Quarterly	378.15	478.11	631.88	537.27	634.17	207.81	543.39	382.74	494.18
All Ages	Monthly	126.54	160.06	211.61	179.89	212.38	69.43	181.94	128.08	165.44

Smoker – Community Rated – ZIP 722

Chart shows \$ amount for all ages.

	Mode	Plan A	Plan B	Plan C	Plan D	Plan F	Plan F*	Plan G	Plan L	Plan M
All Ages	Annual	1,628.00	2,059.00	2,723.00	2,314.00	2,732.00	893.00	2,341.00	1,648.00	2,129.00
All Ages	Quarterly	415.89	525.80	695.12	590.82	697.41	228.47	597.71	420.99	543.65
All Ages	Monthly	139.19	176.04	232.82	197.85	233.59	76.35	200.16	140.90	182.03

Non-Smoker – Community Rated – ZIP 720-721

Chart shows \$ amount for all ages.

	Mode	Plan A	Plan B	Plan C	Plan D	Plan F	Plan F*	Plan G	Plan L	Plan M
All Ages	Annual	1,406.00	1,778.40	2,351.25	1,998.80	2,359.80	771.40	2,021.60	1,423.10	1,838.25
All Ages	Quarterly	359.28	454.24	600.32	510.44	602.50	197.46	516.26	363.64	469.50
All Ages	Monthly	120.21	152.05	201.03	170.90	201.76	65.95	172.85	121.68	157.17

Smoker – Community Rated – ZIP 720-721

Chart shows \$ amount for all ages.

	Mode	Plan A	Plan B	Plan C	Plan D	Plan F	Plan F*	Plan G	Plan L	Plan M
All Ages	Annual	1,546.60	1,956.05	2,586.85	2,198.30	2,595.40	848.35	2,223.95	1,565.60	2,022.55
All Ages	Quarterly	395.13	499.54	660.40	561.32	662.58	217.08	567.86	399.98	516.50
All Ages	Monthly	132.23	167.24	221.18	187.95	221.91	72.53	190.15	133.86	172.93

Non-Smoker – Community Rated – ZIP 716-719, 723-729

Chart shows \$ amount for all ages.

	Mode	Plan A	Plan B	Plan C	Plan D	Plan F	Plan F*	Plan G	Plan L	Plan M
All Ages	Annual	1,258.00	1,591.20	2,103.75	1,788.40	2,111.40	690.20	1,808.80	1,273.30	1,644.75
All Ages	Quarterly	321.54	406.51	537.21	456.79	539.16	176.75	461.99	325.44	420.16
All Ages	Monthly	107.56	136.05	179.87	152.91	180.52	59.01	154.65	108.87	140.63

Smoker – Community Rated – ZIP 716-719, 723-729

Chart shows \$ amount for all ages.

	Mode	Plan A	Plan B	Plan C	Plan D	Plan F	Plan F*	Plan G	Plan L	Plan M
All Ages	Annual	1,383.80	1,750.15	2,314.55	1,966.90	2,322.20	759.05	1,989.85	1,400.80	1,809.65
All Ages	Quarterly	353.62	447.04	590.96	502.31	592.91	194.31	508.16	357.95	462.21
All Ages	Monthly	118.31	149.64	197.89	168.17	198.55	64.90	170.13	119.77	154.73

PREMIUM INFORMATION

We, Thrivent Financial for Lutherans, can only raise your premium if we raise the premium for all policies like yours in this State.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Thrivent Financial for Lutherans, 4321 N. Ballard Road, Appleton, WI 54919-0001. 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 Thrivent Financial for Lutherans 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 and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1100]	\$0	\$[1100] (Part A deductible)
61 st thru 90 th day	All but \$[275] a day	\$[275] a day	\$0
91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[550] a day \$0 \$0	\$[550] a day 100% of Medicare eligible expenses \$0	\$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$[137.50] a day	\$0	Up to \$[137.50] a day
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$[155] 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	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—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			
First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
- First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN B

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1100]	\$[1100] (Part A deductible)	\$0
61 st thru 90 th day	All but \$[275] a day	\$[275] a day	\$0
91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[550] a day \$0 \$0	\$[550] a day 100% of Medicare eligible expenses \$0	\$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$[137.50] a day	\$0	Up to \$[137.50] a day
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$[155] 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	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES —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			
First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
- First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN C

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1100]	\$[1100] (Part A deductible)	\$0
61 st thru 90 th day	All but \$[275] a day	\$[275] a day	\$0
91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[550] a day \$0 \$0	\$[550] a day 100% of Medicare eligible expenses \$0	\$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$[137.50] a day	Up to \$[137.50] a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$[155] 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	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—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			
First \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
- First \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
- Remainder of Medicare Approved Amounts	80%	20%	\$0

(continued)

PLAN C
OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL-- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN D

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1100]	\$[1100] (Part A deductible)	\$0
61 st thru 90 th day	All but \$[275] a day	\$[275] a day	\$0
91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[550] a day \$0 \$0	\$[550] a day 100% of Medicare eligible expenses \$0	\$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$[137.50] a day	Up to \$[137.50] a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$[155] 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	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES —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			
First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
- First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	\$0

(continued)

PLAN D
OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL-- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1100]	\$[1100] (Part A deductible)	\$0
61 st thru 90 th day	All but \$[275] a day	\$[275] a day	\$0
91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[550] a day \$0 \$0	\$[550] a day 100% of Medicare eligible expenses \$0	\$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$[137.50] a day	Up to \$[137.50] a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$[155] 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	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES —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			
First \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
- First \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
- Remainder of Medicare Approved Amounts	80%	20%	\$0

(continued)

PLAN F
OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL-- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[2000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$[2000]. 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	MEDICARE PAYS	AFTER YOU PAY \$[2000] DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$[2000] DEDUCTIBLE**, YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1100]	\$[1100] (Part A deductible)	\$0
61 st thru 90 th day	All but \$[275] a day	\$[275] a day	\$0
91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[550] a day \$0 \$0	\$[550] a day 100% of Medicare eligible expenses \$0	\$0 \$0*** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$[137.50] a day	Up to \$[137.50] a day	\$0
101 st day and after	\$0	\$0	All costs

(continued)

*****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[2000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$[2000]. 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	MEDICARE PAYS	AFTER YOU PAY \$[2000] DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$[2000] DEDUCTIBLE**, YOU PAY
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$[155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[2000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$[2000]. 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	MEDICARE PAYS	AFTER YOU PAY \$[2000] DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$[2000] DEDUCTIBLE**, YOU PAY
MEDICAL EXPENSES —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			
First \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

**HIGH DEDUCTIBLE PLAN F
PARTS A & B**

*Once you have been billed \$[155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[2000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$[2000]. 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	MEDICARE PAYS	AFTER YOU PAY \$[2000] DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$[2000] DEDUCTIBLE**, YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
- First \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
- Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2000] DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$[2000] DEDUCTIBLE**, YOU PAY
FOREIGN TRAVEL-- NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1100]	\$[1100] (Part A deductible)	\$0
61 st thru 90 th day	All but \$[275] a day	\$[275] a day	\$0
91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[550] a day \$0 \$0	\$[550] a day 100% of Medicare eligible expenses \$0	\$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$[137.50] a day	Up to \$[137.50] a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$[155] 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	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES —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			
First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
- First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	\$0

(continued)

PLAN G
OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL-- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN L

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[2310] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1100]	\$[825] (75% of Part A deductible)	\$[275] (25% of Part A deductible)♦
61 st thru 90 th day	All but \$[275] a day	\$[275] a day	\$0
91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[550] a day \$0 \$0	\$[550] a day 100% of Medicare eligible expenses \$0	\$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$[137.50] a day	\$[103.13] a day	Up to \$[34.37] a day♦
101 st day and after	\$0	\$0	All costs

(continued)

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	\$0	75%	25% ♦
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment/coinsurance	25% of copayment/coinsurance ♦

(continued)

PLAN L

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

***Once you have been billed \$[155] 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	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES —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			
First \$[155] of Medicare Approved Amounts***	\$0	\$0	\$[155] (Part B deductible)*** ♦
Preventive Benefits for Medicare Covered Services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\\$2310]*
BLOOD			
First 3 pints	\$0	75%	25% ♦
Next \$[155] of Medicare Approved Amounts***	\$0	\$0	\$[155] (Part B deductible)*** ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[2310] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**PLAN L
PARTS A & B**

***Once you have been billed \$[155] 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	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
- First \$[155] of Medicare Approved Amounts***	\$0	\$0	\$[155] (Part B deductible) ♦
- Remainder of Medicare Approved Amounts	80%	15%	5% ♦

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN M

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1100]	\$[550] (50% of Part A deductible)	\$[550] (50% of Part A deductible)
61 st thru 90 th day	All but \$[275] a day	\$[275] a day	\$0
91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[550] a day \$0 \$0	\$[550] a day 100% of Medicare eligible expenses \$0	\$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$[137.50] a day	Up to \$[137.50] a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN M

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$[155] 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	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES —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			
First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
- First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	\$0

(continued)

PLAN M
OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL-- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

NOTICE: READ THIS OUTLINE OF COVERAGE CAREFULLY. IT IS NOT IDENTICAL TO THE OUTLINE OF COVERAGE PROVIDED UPON APPLICATION AND THE COVERAGE ORIGINALLY APPLIED FOR HAS NOT BEEN ISSUED.



Appleton, Wisconsin • Minneapolis, Minnesota
Thrivent.com • 800-THRIVENT (800-847-4836)

Outline of Medicare Supplement Coverage

Cover page 1 of 2

Benefit Chart of Medicare Supplement Plans Sold with an Effective Date of Coverage on or After June 1, 2010

Plans A, B, C, D, F, high deductible F, G, L, M

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan “A” available. Some plans may not be available in your state.

Plans E, H, I, and J are no longer available for sale.

Basic Benefits:

- **Hospitalization** – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** – First three pints of blood each year.
- **Hospice** – Part A coinsurance.

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

***Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2000] deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed [\$2000]. 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 plan’s separate foreign travel emergency deductible.**

Shaded plans represent those offered by Thrivent Financial for Lutherans.

Benefit Chart of Medicare Supplement Plans Sold with an Effective Date of Coverage on or After June 1, 2010

Plans A, B, C, D, F, high deductible F, G, L, M

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan “A” available. Some plans may not be available in your state.

Plans E, H, I, and J are no longer available for sale.

Basic Benefits:

- **Hospitalization** – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** – First three pints of blood each year.
- **Hospice** – Part A coinsurance.

K	L	M	N
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
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit \$[4620]; paid at 100% after limit reached	Out-of-pocket limit \$[2310]; paid at 100% after limit reached		

Shaded plans represent those offered by Thrivent Financial for Lutherans.

Non-Smoker – Community Rated – ZIP 722

Chart shows \$ amount for all ages.

	Mode	Plan A	Plan B	Plan C	Plan D	Plan F	Plan F*	Plan G	Plan L	Plan M
All Ages	Annual	1,480.00	1,872.00	2,475.00	2,104.00	2,484.00	812.00	2,128.00	1,498.00	1,935.00
All Ages	Quarterly	378.15	478.11	631.88	537.27	634.17	207.81	543.39	382.74	494.18
All Ages	Monthly	126.54	160.06	211.61	179.89	212.38	69.43	181.94	128.08	165.44

Smoker – Community Rated – ZIP 722

Chart shows \$ amount for all ages.

	Mode	Plan A	Plan B	Plan C	Plan D	Plan F	Plan F*	Plan G	Plan L	Plan M
All Ages	Annual	1,628.00	2,059.00	2,723.00	2,314.00	2,732.00	893.00	2,341.00	1,648.00	2,129.00
All Ages	Quarterly	415.89	525.80	695.12	590.82	697.41	228.47	597.71	420.99	543.65
All Ages	Monthly	139.19	176.04	232.82	197.85	233.59	76.35	200.16	140.90	182.03

Non-Smoker – Community Rated – ZIP 720-721

Chart shows \$ amount for all ages.

	Mode	Plan A	Plan B	Plan C	Plan D	Plan F	Plan F*	Plan G	Plan L	Plan M
All Ages	Annual	1,406.00	1,778.40	2,351.25	1,998.80	2,359.80	771.40	2,021.60	1,423.10	1,838.25
All Ages	Quarterly	359.28	454.24	600.32	510.44	602.50	197.46	516.26	363.64	469.50
All Ages	Monthly	120.21	152.05	201.03	170.90	201.76	65.95	172.85	121.68	157.17

Smoker – Community Rated – ZIP 720-721

Chart shows \$ amount for all ages.

	Mode	Plan A	Plan B	Plan C	Plan D	Plan F	Plan F*	Plan G	Plan L	Plan M
All Ages	Annual	1,546.60	1,956.05	2,586.85	2,198.30	2,595.40	848.35	2,223.95	1,565.60	2,022.55
All Ages	Quarterly	395.13	499.54	660.40	561.32	662.58	217.08	567.86	399.98	516.50
All Ages	Monthly	132.23	167.24	221.18	187.95	221.91	72.53	190.15	133.86	172.93

Non-Smoker – Community Rated – ZIP 716-719, 723-729

Chart shows \$ amount for all ages.

	Mode	Plan A	Plan B	Plan C	Plan D	Plan F	Plan F*	Plan G	Plan L	Plan M
All Ages	Annual	1,258.00	1,591.20	2,103.75	1,788.40	2,111.40	690.20	1,808.80	1,273.30	1,644.75
All Ages	Quarterly	321.54	406.51	537.21	456.79	539.16	176.75	461.99	325.44	420.16
All Ages	Monthly	107.56	136.05	179.87	152.91	180.52	59.01	154.65	108.87	140.63

Smoker – Community Rated – ZIP 716-719, 723-729

Chart shows \$ amount for all ages.

	Mode	Plan A	Plan B	Plan C	Plan D	Plan F	Plan F*	Plan G	Plan L	Plan M
All Ages	Annual	1,383.80	1,750.15	2,314.55	1,966.90	2,322.20	759.05	1,989.85	1,400.80	1,809.65
All Ages	Quarterly	353.62	447.04	590.96	502.31	592.91	194.31	508.16	357.95	462.21
All Ages	Monthly	118.31	149.64	197.89	168.17	198.55	64.90	170.13	119.77	154.73

PREMIUM INFORMATION

We, Thrivent Financial for Lutherans, can only raise your premium if we raise the premium for all policies like yours in this State.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Thrivent Financial for Lutherans, 4321 N. Ballard Road, Appleton, WI 54919-0001. 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 Thrivent Financial for Lutherans 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 and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1100]	\$0	\$[1100] (Part A deductible)
61 st thru 90 th day	All but \$[275] a day	\$[275] a day	\$0
91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[550] a day \$0 \$0	\$[550] a day 100% of Medicare eligible expenses \$0	\$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$[137.50] a day	\$0	Up to \$[137.50] a day
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$[155] 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	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—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			
First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
- First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN B

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1100]	\$[1100] (Part A deductible)	\$0
61 st thru 90 th day	All but \$[275] a day	\$[275] a day	\$0
91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[550] a day \$0 \$0	\$[550] a day 100% of Medicare eligible expenses \$0	\$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$[137.50] a day	\$0	Up to \$[137.50] a day
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$[155] 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	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES —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			
First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
- First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN C

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1100]	\$[1100] (Part A deductible)	\$0
61 st thru 90 th day	All but \$[275] a day	\$[275] a day	\$0
91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[550] a day \$0 \$0	\$[550] a day 100% of Medicare eligible expenses \$0	\$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$[137.50] a day	Up to \$[137.50] a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$[155] 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	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—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			
First \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
- First \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
- Remainder of Medicare Approved Amounts	80%	20%	\$0

(continued)

PLAN C
OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL-- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN D

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1100]	\$[1100] (Part A deductible)	\$0
61 st thru 90 th day	All but \$[275] a day	\$[275] a day	\$0
91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[550] a day \$0 \$0	\$[550] a day 100% of Medicare eligible expenses \$0	\$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$[137.50] a day	Up to \$[137.50] a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$[155] 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	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES —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			
First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
- First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	\$0

(continued)

PLAN D
OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL-- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1100]	\$[1100] (Part A deductible)	\$0
61 st thru 90 th day	All but \$[275] a day	\$[275] a day	\$0
91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[550] a day \$0 \$0	\$[550] a day 100% of Medicare eligible expenses \$0	\$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$[137.50] a day	Up to \$[137.50] a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$[155] 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	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES —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			
First \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
- First \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
- Remainder of Medicare Approved Amounts	80%	20%	\$0

(continued)

PLAN F
OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL-- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

**HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[2000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$[2000]. 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	MEDICARE PAYS	AFTER YOU PAY \$[2000] DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$[2000] DEDUCTIBLE**, YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1100]	\$[1100] (Part A deductible)	\$0
61 st thru 90 th day	All but \$[275] a day	\$[275] a day	\$0
91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[550] a day \$0 \$0	\$[550] a day 100% of Medicare eligible expenses \$0	\$0 \$0*** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$[137.50] a day	Up to \$[137.50] a day	\$0
101 st day and after	\$0	\$0	All costs

(continued)

*****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[2000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$[2000]. 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	MEDICARE PAYS	AFTER YOU PAY \$[2000] DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$[2000] DEDUCTIBLE**, YOU PAY
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

**HIGH DEDUCTIBLE PLAN F
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

*Once you have been billed \$[155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[2000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$[2000]. 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	MEDICARE PAYS	AFTER YOU PAY \$[2000] DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$[2000] DEDUCTIBLE**, YOU PAY
MEDICAL EXPENSES —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			
First \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

**HIGH DEDUCTIBLE PLAN F
PARTS A & B**

*Once you have been billed \$[155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[2000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$[2000]. 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	MEDICARE PAYS	AFTER YOU PAY \$[2000] DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$[2000] DEDUCTIBLE**, YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
- First \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
- Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2000] DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$[2000] DEDUCTIBLE**, YOU PAY
FOREIGN TRAVEL-- NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1100]	\$[1100] (Part A deductible)	\$0
61 st thru 90 th day	All but \$[275] a day	\$[275] a day	\$0
91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[550] a day \$0 \$0	\$[550] a day 100% of Medicare eligible expenses \$0	\$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$[137.50] a day	Up to \$[137.50] a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$[155] 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	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES —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			
First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
- First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	\$0

(continued)

PLAN G
OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL-- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN L

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[2310] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1100]	\$[825] (75% of Part A deductible)	\$[275] (25% of Part A deductible)♦
61 st thru 90 th day	All but \$[275] a day	\$[275] a day	\$0
91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[550] a day \$0 \$0	\$[550] a day 100% of Medicare eligible expenses \$0	\$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$[137.50] a day	\$[103.13] a day	Up to \$[34.37] a day♦
101 st day and after	\$0	\$0	All costs

(continued)

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	\$0	75%	25% ♦
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment/coinsurance	25% of copayment/coinsurance ♦

(continued)

PLAN L

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

***Once you have been billed \$[155] 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	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES —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			
First \$[155] of Medicare Approved Amounts***	\$0	\$0	\$[155] (Part B deductible)*** ♦
Preventive Benefits for Medicare Covered Services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\\$2310]*
BLOOD			
First 3 pints	\$0	75%	25% ♦
Next \$[155] of Medicare Approved Amounts***	\$0	\$0	\$[155] (Part B deductible)*** ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[2310] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**PLAN L
PARTS A & B**

***Once you have been billed \$[155] 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	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
- First \$[155] of Medicare Approved Amounts***	\$0	\$0	\$[155] (Part B deductible) ♦
- Remainder of Medicare Approved Amounts	80%	15%	5% ♦

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN M

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1100]	\$[550] (50% of Part A deductible)	\$[550] (50% of Part A deductible)
61 st thru 90 th day	All but \$[275] a day	\$[275] a day	\$0
91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[550] a day \$0 \$0	\$[550] a day 100% of Medicare eligible expenses \$0	\$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$[137.50] a day	Up to \$[137.50] a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN M

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$[155] 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	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES —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			
First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
- First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	\$0

(continued)

PLAN M
OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL-- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

SERFF Tracking Number: THRV-126359093 State: Arkansas
 Filing Company: Thrivent Financial for Lutherans State Tracking Number: 44313
 Company Tracking Number:
 TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010
 Product Name: Medicare Supplement 2010
 Project Name/Number: /

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved 01/22/2010	Medicare Supplement Insurance Plan A	M-MA-MSA (10)	New		AR Proposed Rates Plan A.pdf
Approved 01/22/2010	Medicare Supplement Insurance Plan B	M-MB-MSB (10)	New		AR Proposed Rates Plan B.pdf
Approved 01/22/2010	Medicare Supplement Insurance Plan C	M-MC-MSC (10)	New		AR Proposed Rates Plan C.pdf
Approved 01/22/2010	Medicare Supplement Insurance Plan D	M-MD-MSD (10)	New		AR Proposed Rates Plan D.pdf
Approved 01/22/2010	Medicare Supplement Insurance Plan F	M-MF-MSF (10)	New		AR Proposed Rates Plan F.pdf
Approved 01/22/2010	Medicare Supplement Insurance High Deductible Plan F	M-MH-MSFHI (10)	New		AR Proposed Rates Plan FH.pdf
Approved 01/22/2010	Medicare Supplement Insurance Plan G	M-MG-MSG (10)	New		AR Proposed Rates Plan G.pdf
Approved 01/22/2010	Medicare Supplement Insurance Plan L	M-ML-MSL (10)	New		AR Proposed Rates Plan L.pdf

SERFF Tracking Number: *THR-126359093* *State:* *Arkansas*
Filing Company: *Thrivent Financial for Lutherans* *State Tracking Number:* *44313*
Company Tracking Number:
TOI: *MS09 Medicare Supplement - Other 2010* *Sub-TOI:* *MS09.000 Medicare Supplement Other 2010*
Product Name: *Medicare Supplement 2010*
Project Name/Number: /

Approved Medicare Supplement M-MM-MSM (10) New
01/22/2010 Insurance Plan M

AR Proposed
Rates Plan M.pdf

Appendix A_PropRate
Proposed Rates
Non-Tobacco
MEDICARE SUPPLEMENT
Level Annual Premiums

The following premiums are for 2010:

	Form M-MA-MSA (10) Plan A	Three Digit Zip Code Area Factor	720-721	716-719, 723- 729	722
Age			0.95	0.85	1.00
All Ages	\$1,480.00	Annual	\$1,406.00	\$1,258.00	\$1,480.00
		Quarterly	\$359.28	\$321.54	\$378.15
		Monthly	\$120.21	\$107.56	\$126.54

Quarterly Premium = .255 x Annual Premium + \$.75

Monthly Pre-authorized Check Premium = .0855 x Annual Premium

Thrivent Financial for Lutherans

Appendix A_PropRate
Proposed Rates
Tobacco
MEDICARE SUPPLEMENT
Level Annual Premiums

The following premiums are for 2010:

Age	Form M-MA-MSA (10) Plan A	Three Digit Zip Code Area Factor	720-721	716-719, 723- 729	722
			0.95	0.85	1.00
All Ages	\$1,628.00	Annual	\$1,546.60	\$1,383.80	\$1,628.00
		Quarterly	\$395.13	\$353.62	\$415.89
		Monthly	\$132.23	\$118.31	\$139.19

Quarterly Premium = .255 x Annual Premium + \$.75

Monthly Pre-authorized Check Premium = .0855 x Annual Premium

Thrivent Financial for Lutherans

Appendix B_PropRate
Proposed Rates
Non-Tobacco
MEDICARE SUPPLEMENT
Level Annual Premiums

The following premiums are for 2010:

Age	Form M-MB-MSB (10) Plan B	Three Digit Zip Code Area Factor	720-721	716-719, 723- 729	722
			0.95	0.85	1.00
All Ages	\$1,872.00	Annual	\$1,778.40	\$1,591.20	\$1,872.00
		Quarterly	\$454.24	\$406.51	\$478.11
		Monthly	\$152.05	\$136.05	\$160.06

Quarterly Premium = $.255 \times \text{Annual Premium} + \0.75

Monthly Pre-authorized Check Premium = $.0855 \times \text{Annual Premium}$

Thrivent Financial for Lutherans

Appendix B_PropRate
Proposed Rates
Tobacco
MEDICARE SUPPLEMENT
Level Annual Premiums

The following premiums are for 2010:

	Form M-MB-MSB (10) Plan B	Three Digit Zip Code Area Factor	720-721	716-719, 723- 729	722
Age			0.95	0.85	1.00
All Ages	\$2,059.00	Annual	\$1,956.05	\$1,750.15	\$2,059.00
		Quarterly	\$499.54	\$447.04	\$525.80
		Monthly	\$167.24	\$149.64	\$176.04

Quarterly Premium = .255 x Annual Premium + \$.75

Monthly Pre-authorized Check Premium = .0855 x Annual Premium

Thrivent Financial for Lutherans

Appendix C_PropRate
Proposed Rates
Non-Tobacco
MEDICARE SUPPLEMENT
Level Annual Premiums

The following premiums are for 2010:

Age	Form M-MC-MSC (10) Plan C	Three Digit Zip Code Area Factor	720-721	716-719, 723- 729	722
			0.95	0.85	1.00
All Ages	\$2,475.00	Annual	\$2,351.25	\$2,103.75	\$2,475.00
		Quarterly	\$600.32	\$537.21	\$631.88
		Monthly	\$201.03	\$179.87	\$211.61

Quarterly Premium = .255 x Annual Premium + \$.75

Monthly Pre-authorized Check Premium = .0855 x Annual Premium

Thrivent Financial for Lutherans

Appendix C_PropRate
Proposed Rates
Tobacco
MEDICARE SUPPLEMENT
Level Annual Premiums

The following premiums are for 2010:

	Form M-MC-MSC (10) Plan C	Three Digit Zip Code	720-721	716-719, 723- 729	722
Age		Area Factor	0.95	0.85	1.00
All Ages	\$2,723.00	Annual	\$2,586.85	\$2,314.55	\$2,723.00
		Quarterly	\$660.40	\$590.96	\$695.12
		Monthly	\$221.18	\$197.89	\$232.82

Quarterly Premium = .255 x Annual Premium + \$.75

Monthly Pre-authorized Check Premium = .0855 x Annual Premium

Thrivent Financial for Lutherans

Appendix D_PropRate
Proposed Rates
Non-Tobacco
MEDICARE SUPPLEMENT
Level Annual Premiums

The following premiums are for 2010:

Age	Form M-MD-MSD (10) Plan D	Three Digit Zip Code Area Factor	720-721	716-719, 723- 729	722
			0.95	0.85	1.00
All Ages	\$2,104.00	Annual	\$1,998.80	\$1,788.40	\$2,104.00
		Quarterly	\$510.44	\$456.79	\$537.27
		Monthly	\$170.90	\$152.91	\$179.89

Quarterly Premium = .255 x Annual Premium + \$.75

Monthly Pre-authorized Check Premium = .0855 x Annual Premium

Thrivent Financial for Lutherans

Appendix D_PropRate
Proposed Rates
Tobacco
MEDICARE SUPPLEMENT
Level Annual Premiums

The following premiums are for 2010:

Age	Form M-MD-MSD (10) Plan D	Three Digit Zip Code Area Factor	720-721	716-719, 723- 729	722
			0.95	0.85	1.00
All Ages	\$2,314.00	Annual	\$2,198.30	\$1,966.90	\$2,314.00
		Quarterly	\$561.32	\$502.31	\$590.82
		Monthly	\$187.95	\$168.17	\$197.85

Quarterly Premium = .255 x Annual Premium + \$.75

Monthly Pre-authorized Check Premium = .0855 x Annual Premium

Thrivent Financial for Lutherans

Appendix F_PropRate
Proposed Rates
Non-Tobacco
MEDICARE SUPPLEMENT
Level Annual Premiums

The following premiums are for 2010:

	Form M-MF-MSF (10) Plan F	Three Digit Zip Code Area Factor	720-721	716-719, 723- 729	722
Age			0.95	0.85	1.00
All Ages	\$2,484.00	Annual	\$2,359.80	\$2,111.40	\$2,484.00
		Quarterly	\$602.50	\$539.16	\$634.17
		Monthly	\$201.76	\$180.52	\$212.38

Quarterly Premium = .255 x Annual Premium + \$.75

Monthly Pre-authorized Check Premium = .0855 x Annual Premium

Thrivent Financial for Lutherans

Appendix F_PropRate
Proposed Rates
Tobacco
MEDICARE SUPPLEMENT
Level Annual Premiums

The following premiums are for 2010:

Age	Form M-MF-MSF (10) Plan F	Three Digit Zip Code Area Factor	720-721	716-719, 723- 729	722
			0.95	0.85	1.00
All Ages	\$2,732.00	Annual	\$2,595.40	\$2,322.20	\$2,732.00
		Quarterly	\$662.58	\$592.91	\$697.41
		Monthly	\$221.91	\$198.55	\$233.59

Quarterly Premium = .255 x Annual Premium + \$.75

Monthly Pre-authorized Check Premium = .0855 x Annual Premium

Thrivent Financial for Lutherans

Appendix FH_PropRate
Proposed Rates
Non-Tobacco
MEDICARE SUPPLEMENT
Level Annual Premiums

The following premiums are for 2010:

Age	Form M-MH-MSFHI (10) Plan FH	Three Digit Zip Code Area Factor	720-721	716-719, 723- 729	722
			0.95	0.85	1.00
All Ages	\$812.00	Annual	\$771.40	\$690.20	\$812.00
		Quarterly	\$197.46	\$176.75	\$207.81
		Monthly	\$65.95	\$59.01	\$69.43

Quarterly Premium = .255 x Annual Premium + \$.75

Monthly Pre-authorized Check Premium = .0855 x Annual Premium

Thrivent Financial for Lutherans

Appendix FH_PropRate
Proposed Rates
Tobacco
MEDICARE SUPPLEMENT
Level Annual Premiums

The following premiums are for 2010:

Age	Form M-MH-MSFHI (10) Plan FH	Three Digit Zip Code Area Factor	720-721	716-719, 723- 729	722
			0.95	0.85	1.00
All Ages	\$893.00	Annual	\$848.35	\$759.05	\$893.00
		Quarterly	\$217.08	\$194.31	\$228.47
		Monthly	\$72.53	\$64.90	\$76.35

Quarterly Premium = .255 x Annual Premium + \$.75

Monthly Pre-authorized Check Premium = .0855 x Annual Premium

Thrivent Financial for Lutherans

Appendix G_PropRate
Proposed Rates
Non-Tobacco
MEDICARE SUPPLEMENT
Level Annual Premiums

The following premiums are for 2010:

Age	Form M-MG-MSG (10) Plan G	Three Digit Zip Code Area Factor	720-721	716-719, 723- 729	722
			0.95	0.85	1.00
All Ages	\$2,128.00	Annual	\$2,021.60	\$1,808.80	\$2,128.00
		Quarterly	\$516.26	\$461.99	\$543.39
		Monthly	\$172.85	\$154.65	\$181.94

Quarterly Premium = .255 x Annual Premium + \$.75

Monthly Pre-authorized Check Premium = .0855 x Annual Premium

Thrivent Financial for Lutherans

Appendix G_PropRate
Proposed Rates
Tobacco
MEDICARE SUPPLEMENT
Level Annual Premiums

The following premiums are for 2010:

	Form M-MG-MSG (10) Plan G	Three Digit Zip Code	720-721	716-719, 723- 729	722
Age		Area Factor	0.95	0.85	1.00
All Ages	\$2,341.00	Annual	\$2,223.95	\$1,989.85	\$2,341.00
		Quarterly	\$567.86	\$508.16	\$597.71
		Monthly	\$190.15	\$170.13	\$200.16

Quarterly Premium = $.255 \times \text{Annual Premium} + \0.75

Monthly Pre-authorized Check Premium = $.0855 \times \text{Annual Premium}$

Thrivent Financial for Lutherans

Appendix L_PropRate
Proposed Rates
Non-Tobacco
MEDICARE SUPPLEMENT
Level Annual Premiums

The following premiums are for 2010:

Age	Form M-ML-MSL (10) Plan L	Three Digit Zip Code Area Factor	720-721	716-719, 723- 729	722
			0.95	0.85	1.00
All Ages	\$1,498.00	Annual	\$1,423.10	\$1,273.30	\$1,498.00
		Quarterly	\$363.64	\$325.44	\$382.74
		Monthly	\$121.68	\$108.87	\$128.08

Quarterly Premium = .255 x Annual Premium + \$.75

Monthly Pre-authorized Check Premium = .0855 x Annual Premium

Thrivent Financial for Lutherans

Appendix L_PropRate
Proposed Rates
Tobacco
MEDICARE SUPPLEMENT
Level Annual Premiums

The following premiums are for 2010:

Age	Form M-ML-MSL (10) Plan L	Three Digit Zip Code Area Factor	720-721	716-719, 723- 729	722
			0.95	0.85	1.00
All Ages	\$1,648.00	Annual	\$1,565.60	\$1,400.80	\$1,648.00
		Quarterly	\$399.98	\$357.95	\$420.99
		Monthly	\$133.86	\$119.77	\$140.90

Quarterly Premium = .255 x Annual Premium + \$.75

Monthly Pre-authorized Check Premium = .0855 x Annual Premium

Thrivent Financial for Lutherans

Appendix M_PropRate
Proposed Rates
Non-Tobacco
MEDICARE SUPPLEMENT
Level Annual Premiums

The following premiums are for 2010:

Age	Form M-MM-MSM (10) Plan M	Three Digit Zip Code Area Factor	720-721	716-719, 723- 729	722
			0.95	0.85	1.00
All Ages	\$1,935.00	Annual	\$1,838.25	\$1,644.75	\$1,935.00
		Quarterly	\$469.50	\$420.16	\$494.18
		Monthly	\$157.17	\$140.63	\$165.44

Quarterly Premium = .255 x Annual Premium + \$.75

Monthly Pre-authorized Check Premium = .0855 x Annual Premium

Thrivent Financial for Lutherans

Appendix M_PropRate
Proposed Rates
Tobacco
MEDICARE SUPPLEMENT
Level Annual Premiums

The following premiums are for 2010:

Age	Form M-MM-MSM (10) Plan M	Three Digit Zip Code Area Factor	720-721	716-719, 723- 729	722
			0.95	0.85	1.00
All Ages	\$2,129.00	Annual	\$2,022.55	\$1,809.65	\$2,129.00
		Quarterly	\$516.50	\$462.21	\$543.65
		Monthly	\$172.93	\$154.73	\$182.03

Quarterly Premium = .255 x Annual Premium + \$.75

Monthly Pre-authorized Check Premium = .0855 x Annual Premium

Thrivent Financial for Lutherans

SERFF Tracking Number: THRV-126359093 State: Arkansas
 Filing Company: Thrivent Financial for Lutherans State Tracking Number: 44313
 Company Tracking Number:
 TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010
 Product Name: Medicare Supplement 2010
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Accepted for Informational Purposes	01/22/2010

Comments:

Certifications are attached.

Attachments:

AR Readability Cert.pdf
 AR Life and Health Cert.pdf

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: New application is attached under the Form Schedule.		

Comments:

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage		
Bypass Reason: New Outlines of Coverage are attached under the Form Schedule.		

Comments:

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability	Accepted for Informational Purposes	01/22/2010

Comments:

Attached is a document that explains the variable information in the policy forms.

Attachment:

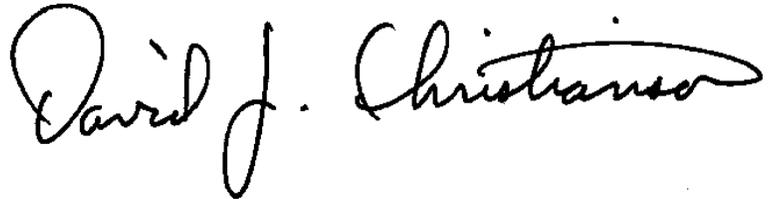
AR Statement of Variability.pdf

ARKANSAS

Readability Certification

I certify that the following forms have the below listed readability scores as calculated by the Flesch Reading Ease Test and that these forms comply with the requirements of Arkansas Stat. Ann. Sections 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<u>Form Number</u>	<u>Flesch Score</u>
M-MA-MSA (10)	51.7
M-MB-MSB (10)	51.6
M-MC-MSC (10)	50.9
M-MD-MSD (10)	51.0
M-MF-MSF (10)	51.1
M-MH-MSFHI (10)	51.0
M-MG-MSG (10)	51.2
M-ML-MSL (10)	51.4
M-MM-MSM (10)	51.0
23798AR R1-10	54.5



December 10, 2009

Date

David J. Christianson

Director

Contract Forms & Compliance

ARKANSAS

CERTIFICATION OF ARANSAS INSURANCE RULE AND REGULATION 19

I certify, to the best of my knowledge and belief, that this filing meets the provisions of Arkansas Insurance Rule and Regulation 19 as well as all applicable requirements of the Arkansas Insurance Department.

A handwritten signature in black ink that reads "David L. Christianson". The signature is written in a cursive style with a large initial "D" and a long horizontal flourish at the end.

David L. Christianson FSA, MAAA, CLU
Director, Contract Forms and Compliance
Product and Solutions Management

Date: December 10, 2009

Arkansas

STATEMENT OF VARIABILITY

Thrivent Financial for Lutherans
Medicare Supplement Insurance Policy forms 2010

Medicare Supplement Insurance Contracts: M-MA-MSA (10), M-MB-MSB (10), M-MC-MSC (10), M-MD-MSD (10),M-MF-MSF (10), M-MH-MSFHI (10), M-MG-MSG (10), M-ML-MSL (10), M-MM-MSM (10)		
Location	Variable Item	Description
Face Page	Officers' signatures	Signatures will change if new officers are elected.
Face Page and Page 3	Name of Insured, age, sex, date of issue	Personal information is different for each contract we issue
Page 3	Service Center address & phone number	Will be updated if information changes
Page 3	Risk Class & Premium Information	Will vary based on the contract issued.
All pages except back cover	Contract Number	Number is different for each contract issued
Outlines of Medicare Supplement Coverage: 26735AR N1-10, A26735AR N1-10		
Location	Variable Item	Description
Benefit Plan Charts	Deductible and copayment/coinsurance amounts	The amounts shown in the charts displaying the benefit plans offered by us are shown in brackets to indicate that they will change based on information received from the Center for Medicare & Medicaid Services (CMS).
Rate Pages	Rates	Premiums listed will change annually if/when approval is received for our rate revision filing that is submitted under separate cover each year.