THRIVENT®
Thrivent Financial for Lutherans
4321 N. Ballard Road, Appleton, WI 54919-0001

Outline of Medicare Supplement Coverage

Benefit Chart of Medicare Supplement Plans sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make available Plans A, B and D or G. Some plans may not be available in your state. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C and F and high deductible F[1].

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 co-payments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or co-payments.
- **Blood** – First three pints of blood each year.
- **Hospice** – Part A coinsurance.

Shaded plans are those offered by Thrivent.

Benefits Note: A ✓ means 100% of the benefit is paid.	**Plans Available to All Applicants**									**Medicare first eligible before 2020 only**		
	A	**B**	**D**	**G**	**G[1]**	**K**	**L**	**M**	**N**	**C**	**F**	**F[1]**
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Medicare Part B coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓ copays apply[3]	✓	✓	
Blood (first three pints)	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Part A hospice care coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Skilled nursing facility coinsurance			✓	✓		50%	75%	✓	✓	✓	✓	
Medicare Part A deductible		✓	✓	✓		50%	75%	50%	✓	✓	✓	
Medicare Part B deductible										✓	✓	
Medicare Part B excess charges				✓							✓	
Foreign travel emergency (up to plan limits)			✓	✓				✓	✓	✓	✓	
Out-of-pocket limit in 2020[2]						$5880[2]	$2940[2]					

[1]Plans F and G also have an option called high deductible Plan F and high deductible Plan G, which pay the same benefits as Plan F or Plan G after one has paid a calendar year $2340 deductible. Benefits from high deductible Plan F or high deductible Plan G will not begin until out-of-pocket expenses exceed $2340. 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, but do not include the plan's separate foreign travel emergency deductible.

[2]Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3]Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

Thrivent – Monthly $ Premium Rates: **Standard Plans – NONSMOKER** For ZIP codes starting with: **155, 157-188, 195-196**

MALE					ATTAINED AGE	FEMALE				
Plan A	**Plan B**	**Plan F^**	**Plan G**	**Plan N**		**Plan A**	**Plan B**	**Plan F^**	**Plan G**	**Plan N**
135.29	137.40	174.01	137.42	102.47	<65	117.64	119.48	151.31	119.50	89.10
135.29	137.40	174.01	137.42	102.47	65	117.64	119.48	151.31	119.50	89.10
135.29	137.40	174.01	137.42	102.47	66	117.64	119.48	151.31	119.50	89.10
135.29	137.40	174.01	137.42	102.47	67	117.64	119.48	151.31	119.50	89.10
141.05	143.35	180.88	143.52	106.94	68	122.65	124.65	157.28	124.80	92.99
146.71	149.26	187.91	149.77	111.42	69	127.58	129.79	163.40	130.23	96.89
152.19	154.67	194.46	155.58	115.65	70	132.34	134.50	169.09	135.29	100.56
156.74	159.73	200.79	161.21	119.88	71	136.30	138.90	174.60	140.18	104.25
161.29	164.79	207.13	166.83	124.12	72	140.26	143.30	180.11	145.07	107.93
165.85	169.85	213.46	172.46	128.36	73	144.22	147.70	185.62	149.96	111.62
170.40	174.91	219.80	178.09	132.60	74	148.18	152.10	191.13	154.86	115.31
174.95	179.97	226.13	183.71	136.84	75	152.13	156.50	196.64	159.75	118.99
179.21	185.07	233.18	189.78	141.59	76	155.84	160.93	202.76	165.03	123.12
183.54	190.26	240.35	195.97	146.43	77	159.60	165.44	209.00	170.41	127.33
188.13	195.73	247.90	202.46	151.50	78	163.59	170.20	215.57	176.06	131.74
192.80	201.30	255.60	209.09	156.68	79	167.66	175.04	222.26	181.82	136.24
197.76	207.19	263.71	216.05	162.12	80	171.96	180.16	229.31	187.87	140.97
202.05	212.47	271.92	223.11	167.83	81	175.69	184.75	236.45	194.01	145.94
206.62	218.07	280.57	230.54	173.84	82	179.67	189.62	243.97	200.47	151.17
211.28	223.78	289.41	238.13	179.99	83	183.73	194.59	251.66	207.07	156.51
216.04	229.61	298.45	245.89	186.27	84	187.86	199.66	259.52	213.82	161.97
220.88	235.56	307.68	253.82	192.69	85	192.07	204.84	267.55	220.71	167.56
226.02	241.55	317.25	261.95	199.24	86	196.54	210.04	275.87	227.78	173.25
231.27	247.69	327.07	270.30	205.96	87	201.10	215.38	284.41	235.04	179.09
236.64	253.97	337.16	278.87	212.86	88	205.77	220.84	293.18	242.50	185.10
241.89	260.14	347.16	287.39	219.74	89	210.34	226.21	301.88	249.90	191.08
247.01	266.19	357.07	295.83	226.57	90	214.80	231.47	310.49	257.24	197.02
250.72	270.67	365.29	302.83	232.35	91	218.02	235.37	317.64	263.33	202.04
254.48	275.23	373.67	309.97	238.25	92	221.29	239.33	324.93	269.54	207.17
257.79	279.31	381.46	316.63	243.78	93	224.16	242.88	331.70	275.33	211.98
261.14	283.45	389.38	323.40	249.41	94	227.08	246.48	338.59	281.22	216.88
264.53	287.65	397.44	330.29	255.14	95	230.03	250.13	345.60	287.21	221.86
270.09	293.69	405.79	337.22	260.50	96	234.86	255.38	352.86	293.24	226.52
275.76	299.86	414.31	344.31	265.97	97	239.79	260.75	360.27	299.40	231.28
281.55	306.16	423.01	351.54	271.56	98	244.83	266.22	367.83	305.68	236.14
287.46	312.59	431.89	358.92	277.26	99	249.97	271.81	375.56	312.10	241.09

To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively.
The rates above do not include a one-time contract fee of $25 or a Household Premium Discount.
^Only applicants **first** eligible for Medicare before January 1, 2020, may purchase Plan F. Rates effective 3-2020

Thrivent – Monthly $ Premium Rates: **Standard Plans – SMOKER** For ZIP codes starting with: **155, 157-188, 195-196**

MALE					ATTAINED AGE	FEMALE				
Plan A	**Plan B**	**Plan F^**	**Plan G**	**Plan N**		**Plan A**	**Plan B**	**Plan F^**	**Plan G**	**Plan N**
155.59	158.01	200.11	158.03	117.84	<65	135.29	137.40	174.01	137.42	102.47
155.59	158.01	200.11	158.03	117.84	65	135.29	137.40	174.01	137.42	102.47
155.59	158.01	200.11	158.03	117.84	66	135.29	137.40	174.01	137.42	102.47
155.59	158.01	200.11	158.03	117.84	67	135.29	137.40	174.01	137.42	102.47
162.21	164.85	208.01	165.05	122.98	68	141.05	143.35	180.88	143.52	106.94
168.72	171.65	216.10	172.24	128.14	69	146.71	149.26	187.91	149.77	111.42
175.02	177.87	223.62	178.92	132.99	70	152.19	154.67	194.46	155.58	115.65
180.25	183.69	230.91	185.39	137.87	71	156.74	159.73	200.79	161.21	119.88
185.49	189.51	238.19	191.86	142.74	72	161.29	164.79	207.13	166.83	124.12
190.73	195.33	245.48	198.33	147.62	73	165.85	169.85	213.46	172.46	128.36
195.96	201.15	252.76	204.80	152.49	74	170.40	174.91	219.80	178.09	132.60
201.20	206.97	260.05	211.27	157.37	75	174.95	179.97	226.13	183.71	136.84
206.09	212.83	268.15	218.25	162.83	76	179.21	185.07	233.18	189.78	141.59
211.07	218.79	276.41	225.36	168.39	77	183.54	190.26	240.35	195.97	146.43
216.35	225.08	285.09	232.83	174.23	78	188.13	195.73	247.90	202.46	151.50
221.72	231.50	293.94	240.45	180.18	79	192.80	201.30	255.60	209.09	156.68
227.42	238.26	303.27	248.46	186.43	80	197.76	207.19	263.71	216.05	162.12
232.36	244.34	312.70	256.57	193.01	81	202.05	212.47	271.92	223.11	167.83
237.62	250.78	322.66	265.12	199.92	82	206.62	218.07	280.57	230.54	173.84
242.98	257.35	332.83	273.85	206.99	83	211.28	223.78	289.41	238.13	179.99
248.44	264.05	343.22	282.77	214.21	84	216.04	229.61	298.45	245.89	186.27
254.01	270.90	353.83	291.90	221.60	85	220.88	235.56	307.68	253.82	192.69
259.92	277.78	364.84	301.24	229.12	86	226.02	241.55	317.25	261.95	199.24
265.96	284.84	376.14	310.85	236.85	87	231.27	247.69	327.07	270.30	205.96
272.14	292.06	387.73	320.70	244.79	88	236.64	253.97	337.16	278.87	212.86
278.18	299.16	399.24	330.49	252.70	89	241.89	260.14	347.16	287.39	219.74
284.07	306.12	410.63	340.20	260.56	90	247.01	266.19	357.07	295.83	226.57
288.33	311.28	420.08	348.26	267.20	91	250.72	270.67	365.29	302.83	232.35
292.65	316.52	429.72	356.47	273.98	92	254.48	275.23	373.67	309.97	238.25
296.45	321.21	438.68	364.12	280.35	93	257.79	279.31	381.46	316.63	243.78
300.31	325.97	447.79	371.91	286.82	94	261.14	283.45	389.38	323.40	249.41
304.21	330.80	457.06	379.83	293.41	95	264.53	287.65	397.44	330.29	255.14
310.60	337.75	466.66	387.81	299.57	96	270.09	293.69	405.79	337.22	260.50
317.12	344.84	476.46	395.95	305.87	97	275.76	299.86	414.31	344.31	265.97
323.78	352.08	486.46	404.27	312.29	98	281.55	306.16	423.01	351.54	271.56
330.58	359.47	496.68	412.76	318.85	99	287.46	312.59	431.89	358.92	277.26

To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively.
The rates above do not include a one-time contract fee of $25 or a Household Premium Discount.
^Only applicants **first** eligible for Medicare before January 1, 2020, may purchase Plan F. Rates effective 3-2020

Thrivent – Monthly $ Premium Rates: **Standard Plans – NONSMOKER** For ZIP codes starting with: **150-154, 156**

MALE					ATTAINED AGE	FEMALE				
Plan A	**Plan B**	**Plan F^**	**Plan G**	**Plan N**		**Plan A**	**Plan B**	**Plan F^**	**Plan G**	**Plan N**
157.11	159.56	202.08	159.59	119.00	<65	136.62	138.75	175.72	138.77	103.48
157.11	159.56	202.08	159.59	119.00	65	136.62	138.75	175.72	138.77	103.48
157.11	159.56	202.08	159.59	119.00	66	136.62	138.75	175.72	138.77	103.48
157.11	159.56	202.08	159.59	119.00	67	136.62	138.75	175.72	138.77	103.48
163.80	166.47	210.05	166.67	124.19	68	142.44	144.76	182.65	144.93	107.99
170.38	173.33	218.22	173.93	129.39	69	148.15	150.72	189.76	151.24	112.52
176.73	179.62	225.82	180.68	134.30	70	153.68	156.19	196.36	157.11	116.78
182.02	185.50	233.18	187.21	139.22	71	158.28	161.30	202.76	162.79	121.06
187.31	191.37	240.53	193.74	144.14	72	162.88	166.41	209.16	168.47	125.34
192.60	197.25	247.89	200.28	149.07	73	167.48	171.52	215.56	174.15	129.62
197.89	203.13	255.25	206.81	153.99	74	172.07	176.63	221.95	179.83	133.90
203.17	209.00	262.60	213.34	158.91	75	176.67	181.74	228.35	185.52	138.19
208.12	214.92	270.79	220.39	164.43	76	180.97	186.89	235.47	191.65	142.98
213.15	220.94	279.12	227.57	170.04	77	185.34	192.12	242.71	197.89	147.86
218.48	227.30	287.89	235.12	175.94	78	189.98	197.65	250.34	204.45	152.99
223.90	233.77	296.83	242.81	181.95	79	194.70	203.28	258.11	211.14	158.22
229.65	240.60	306.24	250.90	188.27	80	199.70	209.22	266.30	218.18	163.71
234.64	246.74	315.77	259.09	194.90	81	204.03	214.55	274.59	225.30	169.48
239.95	253.24	325.82	267.72	201.88	82	208.65	220.21	283.33	232.80	175.55
245.36	259.87	336.09	276.54	209.02	83	213.36	225.98	292.25	240.47	181.76
250.88	266.64	346.59	285.55	216.32	84	218.16	231.87	301.38	248.30	188.10
256.51	273.56	357.31	294.76	223.77	85	223.05	237.87	310.70	256.31	194.59
262.47	280.51	368.42	304.20	231.37	86	228.24	243.92	320.37	264.52	201.19
268.57	287.64	379.83	313.90	239.18	87	233.54	250.12	330.29	272.95	207.98
274.81	294.93	391.54	323.85	247.19	88	238.96	256.46	340.47	281.61	214.95
280.91	302.09	403.16	333.74	255.18	89	244.27	262.69	350.57	290.21	221.90
286.86	309.12	414.66	343.54	263.12	90	249.44	268.80	360.57	298.73	228.80
291.16	314.33	424.21	351.68	269.83	91	253.18	273.33	368.87	305.81	234.63
295.52	319.62	433.94	359.97	276.67	92	256.98	277.94	377.34	313.02	240.59
299.37	324.36	442.98	367.70	283.10	93	260.32	282.06	385.20	319.74	246.17
303.26	329.17	452.19	375.56	289.64	94	263.70	286.24	393.20	326.57	251.86
307.20	334.05	461.54	383.56	296.29	95	267.13	290.48	401.34	333.53	257.65
313.65	341.06	471.24	391.62	302.52	96	272.74	296.58	409.77	340.53	263.06
320.24	348.22	481.13	399.84	308.87	97	278.47	302.80	418.37	347.69	268.58
326.96	355.54	491.24	408.24	315.35	98	284.31	309.16	427.16	354.99	274.22
333.83	363.00	501.55	416.81	321.98	99	290.28	315.65	436.13	362.44	279.98

To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively.
The rates above do not include a one-time contract fee of $25 or a Household Premium Discount.
^Only applicants **first** eligible for Medicare before January 1, 2020, may purchase Plan F. Rates effective 3-2020

Thrivent – Monthly $ Premium Rates: **Standard Plans – SMOKER** For ZIP codes starting with: **150-154, 156**

MALE					ATTAINED AGE	FEMALE				
Plan A	**Plan B**	**Plan F^**	**Plan G**	**Plan N**		**Plan A**	**Plan B**	**Plan F^**	**Plan G**	**Plan N**
180.68	183.49	232.39	183.52	136.85	<65	157.11	159.56	202.08	159.59	119.00
180.68	183.49	232.39	183.52	136.85	65	157.11	159.56	202.08	159.59	119.00
180.68	183.49	232.39	183.52	136.85	66	157.11	159.56	202.08	159.59	119.00
180.68	183.49	232.39	183.52	136.85	67	157.11	159.56	202.08	159.59	119.00
188.37	191.44	241.56	191.67	142.81	68	163.80	166.47	210.05	166.67	124.19
195.93	199.33	250.96	200.02	148.80	69	170.38	173.33	218.22	173.93	129.39
203.24	206.56	259.69	207.78	154.44	70	176.73	179.62	225.82	180.68	134.30
209.32	213.32	268.15	215.29	160.10	71	182.02	185.50	233.18	187.21	139.22
215.41	220.08	276.61	222.80	165.76	72	187.31	191.37	240.53	193.74	144.14
221.49	226.84	285.07	230.32	171.43	73	192.60	197.25	247.89	200.28	149.07
227.57	233.60	293.53	237.83	177.09	74	197.89	203.13	255.25	206.81	153.99
233.65	240.35	301.99	245.34	182.75	75	203.17	209.00	262.60	213.34	158.91
239.33	247.16	311.40	253.45	189.09	76	208.12	214.92	270.79	220.39	164.43
245.12	254.08	320.99	261.71	195.55	77	213.15	220.94	279.12	227.57	170.04
251.24	261.39	331.07	270.39	202.33	78	218.48	227.30	287.89	235.12	175.94
257.49	268.83	341.35	279.23	209.24	79	223.90	233.77	296.83	242.81	181.95
264.10	276.69	352.18	288.54	216.50	80	229.65	240.60	306.24	250.90	188.27
269.83	283.75	363.14	297.96	224.14	81	234.64	246.74	315.77	259.09	194.90
275.94	291.22	374.70	307.88	232.16	82	239.95	253.24	325.82	267.72	201.88
282.17	298.85	386.51	318.02	240.37	83	245.36	259.87	336.09	276.54	209.02
288.51	306.64	398.57	328.38	248.76	84	250.88	266.64	346.59	285.55	216.32
294.98	314.59	410.90	338.98	257.34	85	256.51	273.56	357.31	294.76	223.77
301.84	322.59	423.68	349.83	266.08	86	262.47	280.51	368.42	304.20	231.37
308.86	330.78	436.80	360.98	275.05	87	268.57	287.64	379.83	313.90	239.18
316.03	339.17	450.27	372.43	284.27	88	274.81	294.93	391.54	323.85	247.19
323.04	347.41	463.63	383.80	293.46	89	280.91	302.09	403.16	333.74	255.18
329.88	355.49	476.86	395.07	302.58	90	286.86	309.12	414.66	343.54	263.12
334.83	361.48	487.84	404.43	310.30	91	291.16	314.33	424.21	351.68	269.83
339.85	367.57	499.03	413.96	318.17	92	295.52	319.62	433.94	359.97	276.67
344.27	373.02	509.43	422.85	325.56	93	299.37	324.36	442.98	367.70	283.10
348.75	378.55	520.01	431.89	333.08	94	303.26	329.17	452.19	375.56	289.64
353.28	384.15	530.78	441.09	340.74	95	307.20	334.05	461.54	383.56	296.29
360.70	392.22	541.92	450.36	347.89	96	313.65	341.06	471.24	391.62	302.52
368.27	400.46	553.30	459.81	355.20	97	320.24	348.22	481.13	399.84	308.87
376.01	408.87	564.92	469.47	362.66	98	326.96	355.54	491.24	408.24	315.35
383.90	417.45	576.78	479.33	370.27	99	333.83	363.00	501.55	416.81	321.98

To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively.
The rates above do not include a one-time contract fee of $25 or a Household Premium Discount.
^Only applicants **first** eligible for Medicare before January 1, 2020, may purchase Plan F. Rates effective 3-2020

Thrivent – Monthly $ Premium Rates: **Standard Plans – NONSMOKER** For ZIP codes starting with: **189-194**

MALE					ATTAINED AGE	FEMALE				
Plan A	**Plan B**	**Plan F^**	**Plan G**	**Plan N**		**Plan A**	**Plan B**	**Plan F^**	**Plan G**	**Plan N**
174.57	177.29	224.53	177.32	132.22	<65	151.80	154.16	195.25	154.19	114.97
174.57	177.29	224.53	177.32	132.22	65	151.80	154.16	195.25	154.19	114.97
174.57	177.29	224.53	177.32	132.22	66	151.80	154.16	195.25	154.19	114.97
174.57	177.29	224.53	177.32	132.22	67	151.80	154.16	195.25	154.19	114.97
182.00	184.97	233.39	185.19	137.98	68	158.26	160.84	202.95	161.03	119.99
189.31	192.59	242.47	193.25	143.77	69	164.61	167.47	210.84	168.05	125.02
196.37	199.58	250.91	200.75	149.22	70	170.76	173.55	218.18	174.57	129.76
202.25	206.11	259.09	208.01	154.69	71	175.87	179.22	225.29	180.88	134.51
208.12	212.64	267.26	215.27	160.16	72	180.98	184.90	232.40	187.19	139.27
214.00	219.17	275.43	222.53	165.63	73	186.08	190.58	239.51	193.50	144.03
219.87	225.70	283.61	229.79	171.10	74	191.19	196.26	246.62	199.82	148.78
225.75	232.23	291.78	237.05	176.57	75	196.30	201.94	253.72	206.13	153.54
231.24	238.80	300.87	244.88	182.70	76	201.08	207.65	261.63	212.94	158.87
236.83	245.49	310.13	252.86	188.94	77	205.94	213.47	269.68	219.88	164.29
242.75	252.55	319.88	261.24	195.49	78	211.09	219.61	278.15	227.17	169.99
248.78	259.74	329.81	269.79	202.17	79	216.33	225.86	286.79	234.60	175.80
255.17	267.34	340.27	278.78	209.18	80	221.89	232.47	295.89	242.42	181.90
260.71	274.15	350.86	287.88	216.56	81	226.70	238.39	305.10	250.33	188.31
266.61	281.38	362.03	297.47	224.31	82	231.83	244.67	314.81	258.67	195.06
272.63	288.75	373.44	307.26	232.24	83	237.07	251.09	324.73	267.19	201.95
278.76	296.27	385.10	317.28	240.35	84	242.40	257.63	334.87	275.89	209.00
285.01	303.95	397.01	327.51	248.64	85	247.83	264.30	345.22	284.79	216.21
291.64	311.68	409.36	338.00	257.08	86	253.60	271.03	355.96	293.92	223.55
298.41	319.60	422.03	348.78	265.75	87	259.49	277.91	366.98	303.28	231.09
305.34	327.70	435.04	359.83	274.66	88	265.51	284.95	378.30	312.90	238.84
312.12	335.66	447.95	370.82	283.54	89	271.41	291.88	389.52	322.46	246.55
318.73	343.47	460.73	381.71	292.35	90	277.16	298.67	400.64	331.93	254.22
323.51	349.26	471.34	390.75	299.81	91	281.31	303.70	409.86	339.78	260.70
328.36	355.14	482.15	399.97	307.41	92	285.53	308.82	419.26	347.80	267.32
332.63	360.41	492.21	408.55	314.55	93	289.24	313.40	428.00	355.26	273.53
336.95	365.75	502.43	417.29	321.82	94	293.00	318.04	436.89	362.86	279.84
341.33	371.16	512.83	426.18	329.22	95	296.81	322.75	445.94	370.59	286.28
348.50	378.96	523.60	435.13	336.13	96	303.04	329.53	455.30	378.37	292.29
355.82	386.92	534.59	444.27	343.19	97	309.41	336.45	464.86	386.32	298.42
363.29	395.04	545.82	453.60	350.39	98	315.90	343.52	474.62	394.43	304.69
370.92	403.34	557.28	463.12	357.75	99	322.54	350.73	484.59	402.71	311.09

To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively.
The rates above do not include a one-time contract fee of $25 or a Household Premium Discount.
^Only applicants **first** eligible for Medicare before January 1, 2020, may purchase Plan F. Rates effective 3-2020

Thrivent – Monthly $ Premium Rates: **Standard Plans – SMOKER** For ZIP codes starting with: **189-194**

MALE					ATTAINED AGE	FEMALE				
Plan A	**Plan B**	**Plan F^**	**Plan G**	**Plan N**		**Plan A**	**Plan B**	**Plan F^**	**Plan G**	**Plan N**
200.76	203.88	258.21	203.92	152.05	<65	174.57	177.29	224.53	177.32	132.22
200.76	203.88	258.21	203.92	152.05	65	174.57	177.29	224.53	177.32	132.22
200.76	203.88	258.21	203.92	152.05	66	174.57	177.29	224.53	177.32	132.22
200.76	203.88	258.21	203.92	152.05	67	174.57	177.29	224.53	177.32	132.22
209.30	212.71	268.40	212.96	158.68	68	182.00	184.97	233.39	185.19	137.98
217.70	221.48	278.84	222.24	165.34	69	189.31	192.59	242.47	193.25	143.77
225.83	229.52	288.55	230.86	171.60	70	196.37	199.58	250.91	200.75	149.22
232.58	237.03	297.95	239.21	177.89	71	202.25	206.11	259.09	208.01	154.69
239.34	244.53	307.35	247.56	184.18	72	208.12	212.64	267.26	215.27	160.16
246.10	252.04	316.75	255.91	190.47	73	214.00	219.17	275.43	222.53	165.63
252.85	259.55	326.15	264.26	196.76	74	219.87	225.70	283.61	229.79	171.10
259.61	267.06	335.55	272.61	203.05	75	225.75	232.23	291.78	237.05	176.57
265.93	274.62	346.01	281.62	210.10	76	231.24	238.80	300.87	244.88	182.70
272.35	282.31	356.66	290.79	217.28	77	236.83	245.49	310.13	252.86	188.94
279.16	290.43	367.86	300.43	224.81	78	242.75	252.55	319.88	261.24	195.49
286.10	298.71	379.28	310.26	232.49	79	248.78	259.74	329.81	269.79	202.17
293.45	307.44	391.31	320.60	240.56	80	255.17	267.34	340.27	278.78	209.18
299.81	315.27	403.49	331.06	249.04	81	260.71	274.15	350.86	287.88	216.56
306.60	323.58	416.33	342.09	257.96	82	266.61	281.38	362.03	297.47	224.31
313.52	332.06	429.45	353.35	267.08	83	272.63	288.75	373.44	307.26	232.24
320.57	340.71	442.86	364.87	276.40	84	278.76	296.27	385.10	317.28	240.35
327.76	349.54	456.56	376.64	285.93	85	285.01	303.95	397.01	327.51	248.64
335.38	358.43	470.76	388.70	295.64	86	291.64	311.68	409.36	338.00	257.08
343.18	367.53	485.34	401.09	305.61	87	298.41	319.60	422.03	348.78	265.75
351.14	376.85	500.30	413.81	315.86	88	305.34	327.70	435.04	359.83	274.66
358.94	386.01	515.14	426.45	326.06	89	312.12	335.66	447.95	370.82	283.54
366.54	394.99	529.84	438.97	336.20	90	318.73	343.47	460.73	381.71	292.35
372.04	401.65	542.04	449.36	344.78	91	323.51	349.26	471.34	390.75	299.81
377.62	408.41	554.48	459.96	353.53	92	328.36	355.14	482.15	399.97	307.41
382.52	414.47	566.04	469.84	361.74	93	332.63	360.41	492.21	408.55	314.55
387.50	420.61	577.79	479.88	370.09	94	336.95	365.75	502.43	417.29	321.82
392.53	426.84	589.75	490.10	378.60	95	341.33	371.16	512.83	426.18	329.22
400.77	435.80	602.14	500.40	386.55	96	348.50	378.96	523.60	435.13	336.13
409.19	444.95	614.78	510.91	394.67	97	355.82	386.92	534.59	444.27	343.19
417.78	454.30	627.69	521.64	402.95	98	363.29	395.04	545.82	453.60	350.39
426.56	463.84	640.87	532.59	411.42	99	370.92	403.34	557.28	463.12	357.75

To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively.
The rates above do not include a one-time contract fee of $25 or a Household Premium Discount.
^Only applicants **first** eligible for Medicare before January 1, 2020, may purchase Plan F. Rates effective 3-2020

PREMIUM INFORMATION

We, Thrivent Financial for Lutherans, can only raise your premium if we raise the premium for all policies like yours in this Commonwealth. Because your premium is based on attained age, your renewal premium will increase due to age; it will increase on or after the contract anniversary.

HOUSEHOLD PREMIUM DISCOUNT

If for the past year you resided with another adult with whom you are in a legal relationship, who is not required to have an insurance contract with us, you will be eligible for a household premium discount. The discounted premium will be priced 7% lower than the rates illustrated. Your contract's household premium discount will be removed if the other adult no longer resides with you (other than in the case of his or her death).

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 Service Center, PO Box 14008, Clearwater, FL 33766-4008. 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 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.

Read 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 $1408	$0	$1408 (Part A deductible)
61st through 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $704 a day	$704 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- Beyond the additional 365 days	$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
21st through 100th day	All but $176 a day	$0	Up to $176 a day
101st 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 Basic 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 EXPENSES – PER CALENDAR YEAR

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

SERVICES	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 $198 of Medicare Approved Amounts*	$0	$0	$198 (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 $198 of Medicare Approved Amounts*	$0	$0	$198 (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 $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

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 $1408	$1408 (Part A deductible)	$0
61st through 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $704 a day	$704 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- Beyond the additional 365 days	$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
21st through 100th day	All but $176 a day	$0	Up to $176 a day
101st 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 Basic 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 EXPENSES – PER CALENDAR YEAR

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

SERVICES	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 $198 of Medicare Approved Amounts*	$0	$0	$198 (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 $198 of Medicare Approved Amounts*	$0	$0	$198 (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 $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

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 $1408	$1408 (Part A deductible)	$0
61st through 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $704 a day	$704 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- Beyond the additional 365 days	$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
21st through 100th day	All but $176 a day	Up to $176 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0
You must meet Medicare's requirements, including a doctor's certification of terminal illness			

(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 Basic 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 EXPENSES – PER CALENDAR YEAR

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

SERVICES	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 $198 of Medicare Approved Amounts*	$0	$198 (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 $198 of Medicare Approved Amounts*	$0	$198 (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 $198 of Medicare Approved Amounts*	$0	$198 (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

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

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 $1408	$1408 (Part A deductible)	$0
61st through 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $704 a day	$704 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- Beyond the additional 365 days	$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
21st through 100th day	All but $176 a day	Up to $176 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0
You must meet Medicare's requirements, including a doctor's certification of terminal illness			

(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 Basic 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 EXPENSES – PER CALENDAR YEAR

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

SERVICES	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 $198 of Medicare Approved Amounts*	$0	$0	$198 (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 $198 of Medicare Approved Amounts*	$0	$0	$198 (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 $198 of Medicare Approved Amounts*	$0	$0	$198 (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

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

PLAN N
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 $1408	$1408 (Part A deductible)	$0
61st through 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $704 a day	$704 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- Beyond the additional 365 days	$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
21st through 100th day	All but $176 a day	Up to $176 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0
You must meet Medicare's requirements, including a doctor's certification of terminal illness			

(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 Basic 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 N
MEDICARE (PART B) – MEDICAL EXPENSES – PER CALENDAR YEAR

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

SERVICES	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 $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN N
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 $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

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

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

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Medicare Supplement Open Enrollment

The following provides you with information about Medicare Supplement Open Enrollment and eligibility criteria. The application for Medicare Supplement coverage to be issued under Open Enrollment must be made no later 6 months after the first of the month during which you were enrolled in Medicare Part B.

1. An issuer may not deny or condition the issuance or effectiveness of a Medicare supplement policy or certificate available for sale in the Commonwealth of Pennsylvania, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the 6-month period beginning with the first day of the first month in which an individual enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to applicants who qualify under this subsection without regard to age.

2. If an applicant qualifies under the above criteria and submits an application during the time period referenced above and, as of the date of application, has had a continuous period of creditable coverage of at least 6 months, the issuer may not exclude benefits based on a preexisting condition.

3. If an applicant qualifies under the above criteria and submits an application during the time period referenced above and, as of the date of application, has had a continuous period of creditable coverage that is less than 6 months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date.

4. Except as noted above and elsewhere in Pennsylvania Code (relating to prohibition against preexisting conditions, waiting periods, elimination periods and probationary periods in replacement policies or certificates; and guarantee issue for eligible persons), the language above will not be constructed as preventing the exclusion of benefits under a policy, during the first 6 months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the 6 months before it became effective.

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Medicare Supplement
Guaranteed Issue for Eligible Person

The following are definitions of categories of individuals who are eligible for Guaranteed Issue. If any of the definitions apply to you, please complete an Application for Medicare Supplement Insurance and submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment. The application for coverage must be made no later than 63 days after the effective date of termination, disenrollment, or enrollment in Medicare Part D.

1. Enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all supplemental Medicare health benefits; or enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates, or the plan ceases to provide health benefits to the individual because the individual leaves the plan.

2. Enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PAC) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described as follows that would permit discontinuance of the individual's enrollment with the provider if the individual were enrolled in a Medicare Advantage plan: (i) The certification of the organization or plan under this part has been terminated, (ii) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, (iii) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances, (iv) The individual demonstrates that (A) the organization offering the plan substantially violated a material provision of the organization's contract, or (B) the organization, or producer or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual, or (v)The individual meets other exceptional conditions the HHS Secretary may provide.

3. Enrolled with an eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost plan), enrolled with a similar organization operating under demonstration project authority, effective for periods before April 1, 1999, enrolled with an organization under an agreement under section 1833(a)(1)(A)of the Social Security Act (health care prepayment plan), or enrolled with an organization under a Medicare Select policy, and the individual's enrollment ceases under circumstances similar to those described in 2. (i), (ii), (iii), and (iv) above.

4. Enrolled under a Medicare supplement policy and the enrollment ceases because one of the following applies: (i) The insolvency of the issuer or bankruptcy of the nonissuer organization or of other involuntary termination of coverage or enrollment under the policy, (ii) The issuer of the policy substantially violated a material provision of the policy, or (iii) The issuer, or a producer or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.

5. Enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or any Medicare Select policy and the subsequent enrollment under this paragraph is terminated by the enrollee during the first 12 months of the subsequent enrollment.

6. Upon first becoming eligible for benefits under Part A and enrolled in Part B, if eligible, of Medicare, enrolls in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan or program within 12 months after the effective date of enrollment.

7. Enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy.