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 with Effective Dates on or after June 1, 2010

Plans A, F, G, N

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.

Plans C, F, and high deductible F are no longer available for sale to those who are newly eligible, as defined in 14VAC5-170-87, on or after January 1, 2020.

Note that the numeric figures in the following charts, including out-of-pocket limits and deductible amounts, are current as of January 1, 2020, and are subject to change.

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.

Shaded plans shown below represent those offered by Thrivent.

A	B	C	D	F	F*	G
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance		Basic, including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible
		Part B Deductible		Part B Deductible		
				Part B Excess (100%)		Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		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 $2340 deductible. Benefits from high deductible Plan F 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 and Part B, but do not include the plan's separate foreign travel emergency deductible.

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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.

Plans C, F, and high deductible F are no longer available for sale to those who are newly eligible, as defined in 14VAC5-170-87, on or after January 1, 2020.

Note that the numeric figures in the following charts, including out-of-pocket limits and deductible amounts, are current as of January 1, 2020, and are subject to change.

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.

Shaded plans shown below represent those offered by Thrivent.

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 $5880; paid at 100% after limit reached	Out-of-pocket limit $2940; paid at 100% after limit reached		

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.

NOTE: While the cost of this policy at your present age may be lower than the cost of Medicare Supplement coverage that is based on issue age or is community rated, it is important to compare the potential cost of these policies over the life of the coverage. Premiums for other Medicare Supplement policies that are issue age or community rated do not increase due to changes in your age.

HOUSEHOLD PREMIUM DISCOUNT

If for the past year you resided with at least one, but no more than three, other adults who are age 50 or older, 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).

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

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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. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✓ means 100% of the benefit is paid. *Shaded plans shown below represent those offered by Thrivent.*

Benefits	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 a high deductible option which require first paying a plan deductible of $2340 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[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: **226-231, 238-246**

MALE				ATTAINED AGE	FEMALE			
Plan A	**Plan F^**	**Plan G**	**Plan N**		**Plan A**	**Plan F^**	**Plan G**	**Plan N**
113.52	147.68	116.62	86.96	65	98.71	128.41	101.41	75.62
113.52	147.68	116.62	86.96	66	98.71	128.41	101.41	75.62
113.52	147.68	116.62	86.96	67	98.71	128.41	101.41	75.62
118.35	153.50	121.80	90.75	68	102.92	133.48	105.91	78.92
123.10	159.47	127.10	94.56	69	107.05	138.67	110.52	82.23
127.70	165.03	132.03	98.14	70	111.04	143.50	114.81	85.34
131.52	170.40	136.81	101.74	71	114.36	148.18	118.96	88.47
135.34	175.78	141.58	105.34	72	117.69	152.85	123.12	91.60
139.16	181.16	146.36	108.94	73	121.01	157.53	127.27	94.73
142.98	186.53	151.13	112.53	74	124.33	162.20	131.42	97.86
146.80	191.91	155.91	116.13	75	127.65	166.87	135.57	100.98
150.37	197.89	161.06	120.16	76	130.76	172.08	140.05	104.49
154.01	203.98	166.31	124.27	77	133.92	177.37	144.62	108.06
157.86	210.39	171.82	128.57	78	137.27	182.94	149.41	111.80
161.78	216.92	177.44	132.97	79	140.68	188.62	154.30	115.62
165.93	223.80	183.36	137.58	80	144.29	194.61	159.44	119.64
169.54	230.76	189.34	142.43	81	147.42	200.66	164.65	123.86
173.37	238.11	195.65	147.53	82	150.76	207.05	170.13	128.29
177.29	245.61	202.09	152.75	83	154.16	213.58	175.73	132.82
181.27	253.28	208.68	158.08	84	157.63	220.24	181.46	137.46
185.34	261.11	215.41	163.53	85	161.16	227.06	187.31	142.20
189.65	269.24	222.31	169.08	86	164.91	234.12	193.31	147.03
194.05	277.57	229.39	174.79	87	168.74	241.37	199.47	151.99
198.56	286.13	236.67	180.65	88	172.66	248.81	205.80	157.08
202.97	294.62	243.89	186.48	89	176.49	256.19	212.08	162.16
207.27	303.03	251.06	192.28	90	180.23	263.50	218.31	167.20
210.37	310.00	257.00	197.18	91	182.93	269.57	223.48	171.46
213.53	317.12	263.06	202.19	92	185.68	275.75	228.75	175.82
216.31	323.73	268.71	206.88	93	188.09	281.50	233.66	179.90
219.12	330.45	274.46	211.66	94	190.54	287.35	238.66	184.06
221.96	337.29	280.30	216.53	95	193.01	293.29	243.74	188.29
226.62	344.37	286.19	221.08	96	197.07	299.45	248.86	192.24
231.38	351.61	292.20	225.72	97	201.20	305.74	254.08	196.28
236.24	358.99	298.33	230.46	98	205.43	312.16	259.42	200.40
241.20	366.53	304.60	235.30	99	209.74	318.72	264.87	204.61

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 5-2020

Thrivent – Monthly $ Premium Rates: **Standard Plans – SMOKER** For ZIP codes starting with: **226-231, 238-246**

MALE				ATTAINED AGE	FEMALE			
Plan A	**Plan F^**	**Plan G**	**Plan N**		**Plan A**	**Plan F^**	**Plan G**	**Plan N**
130.55	169.83	134.12	100.01	65	113.52	147.68	116.62	86.96
130.55	169.83	134.12	100.01	66	113.52	147.68	116.62	86.96
130.55	169.83	134.12	100.01	67	113.52	147.68	116.62	86.96
136.11	176.53	140.07	104.37	68	118.35	153.50	121.80	90.75
141.57	183.40	146.17	108.74	69	123.10	159.47	127.10	94.56
146.85	189.78	151.84	112.87	70	127.70	165.03	132.03	98.14
151.25	195.96	157.33	117.00	71	131.52	170.40	136.81	101.74
155.64	202.15	162.82	121.14	72	135.34	175.78	141.58	105.34
160.03	208.33	168.31	125.28	73	139.16	181.16	146.36	108.94
164.43	214.51	173.80	129.41	74	142.98	186.53	151.13	112.53
168.82	220.69	179.29	133.55	75	146.80	191.91	155.91	116.13
172.93	227.57	185.22	138.19	76	150.37	197.89	161.06	120.16
177.11	234.57	191.25	142.91	77	154.01	203.98	166.31	124.27
181.54	241.94	197.59	147.86	78	157.86	210.39	171.82	128.57
186.05	249.46	204.06	152.91	79	161.78	216.92	177.44	132.97
190.82	257.37	210.86	158.22	80	165.93	223.80	183.36	137.58
194.97	265.38	217.74	163.80	81	169.54	230.76	189.34	142.43
199.38	273.82	224.99	169.66	82	173.37	238.11	195.65	147.53
203.88	282.45	232.40	175.66	83	177.29	245.61	202.09	152.75
208.46	291.27	239.98	181.79	84	181.27	253.28	208.68	158.08
213.14	300.28	247.72	188.06	85	185.34	261.11	215.41	163.53
218.09	309.62	255.65	194.45	86	189.65	269.24	222.31	169.08
223.16	319.21	263.80	201.00	87	194.05	277.57	229.39	174.79
228.34	329.05	272.16	207.74	88	198.56	286.13	236.67	180.65
233.41	338.81	280.48	214.45	89	202.97	294.62	243.89	186.48
238.36	348.48	288.72	221.12	90	207.27	303.03	251.06	192.28
241.93	356.50	295.55	226.76	91	210.37	310.00	257.00	197.18
245.56	364.68	302.52	232.52	92	213.53	317.12	263.06	202.19
248.75	372.29	309.02	237.92	93	216.31	323.73	268.71	206.88
251.98	380.02	315.62	243.41	94	219.12	330.45	274.46	211.66
255.26	387.88	322.35	249.01	95	221.96	337.29	280.30	216.53
260.62	396.03	329.11	254.24	96	226.62	344.37	286.19	221.08
266.09	404.35	336.03	259.58	97	231.38	351.61	292.20	225.72
271.68	412.84	343.08	265.03	98	236.24	358.99	298.33	230.46
277.38	421.51	350.29	270.59	99	241.20	366.53	304.60	235.30

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 5-2020

Thrivent – Monthly $ Premium Rates: **Standard Plans – NONSMOKER** For ZIP codes starting with: **232-236**

MALE				ATTAINED AGE	FEMALE			
Plan A	**Plan F^**	**Plan G**	**Plan N**		**Plan A**	**Plan F^**	**Plan G**	**Plan N**
132.69	172.61	136.31	101.64	65	115.38	150.10	118.53	88.39
132.69	172.61	136.31	101.64	66	115.38	150.10	118.53	88.39
132.69	172.61	136.31	101.64	67	115.38	150.10	118.53	88.39
138.34	179.42	142.36	106.07	68	120.29	156.02	123.79	92.24
143.89	186.40	148.56	110.53	69	125.12	162.09	129.18	96.11
149.26	192.89	154.33	114.71	70	129.79	167.73	134.20	99.75
153.72	199.17	159.91	118.92	71	133.67	173.19	139.05	103.41
158.19	205.46	165.49	123.12	72	137.56	178.66	143.90	107.06
162.65	211.74	171.07	127.33	73	141.44	184.12	148.76	110.72
167.12	218.02	176.65	131.53	74	145.32	189.59	153.61	114.38
171.59	224.31	182.23	135.74	75	149.21	195.05	158.46	118.03
175.76	231.30	188.25	140.45	76	152.84	201.13	163.70	122.13
180.01	238.42	194.39	145.25	77	156.53	207.32	169.03	126.30
184.51	245.91	200.83	150.28	78	160.44	213.83	174.64	130.68
189.09	253.54	207.40	155.41	79	164.43	220.47	180.35	135.14
193.95	261.58	214.31	160.81	80	168.65	227.46	186.36	139.83
198.16	269.72	221.31	166.48	81	172.31	234.54	192.44	144.77
202.64	278.31	228.68	172.44	82	176.21	242.01	198.85	149.95
207.22	287.08	236.21	178.54	83	180.19	249.63	205.40	155.25
211.88	296.04	243.91	184.77	84	184.24	257.43	212.09	160.67
216.63	305.20	251.77	191.14	85	188.37	265.39	218.93	166.21
221.67	314.69	259.84	197.63	86	192.75	273.65	225.95	171.85
226.82	324.44	268.12	204.30	87	197.23	282.12	233.15	177.65
232.08	334.44	276.62	211.14	88	201.81	290.81	240.54	183.60
237.23	344.36	285.07	217.97	89	206.29	299.45	247.89	189.54
242.26	354.19	293.44	224.75	90	210.66	307.99	255.17	195.43
245.89	362.34	300.39	230.48	91	213.82	315.08	261.21	200.41
249.58	370.66	307.47	236.32	92	217.03	322.31	267.37	205.50
252.83	378.38	314.08	241.81	93	219.85	329.03	273.11	210.27
256.11	386.24	320.79	247.40	94	222.70	335.86	278.95	215.13
259.44	394.24	327.62	253.09	95	225.60	342.81	284.89	220.07
264.89	402.51	334.50	258.40	96	230.34	350.01	290.87	224.70
270.45	410.97	341.53	263.83	97	235.17	357.36	296.98	229.41
276.13	419.60	348.70	269.37	98	240.11	364.87	303.22	234.23
281.93	428.41	356.02	275.02	99	245.15	372.53	309.59	239.15

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^Only applicants **first** eligible for Medicare before January 1, 2020, may purchase Plan F. Rates effective 5-2020

Thrivent – Monthly $ Premium Rates: **Standard Plans – SMOKER** For ZIP codes starting with: **232-236**

MALE				ATTAINED AGE	FEMALE			
Plan A	**Plan F^**	**Plan G**	**Plan N**		**Plan A**	**Plan F^**	**Plan G**	**Plan N**
152.59	198.50	156.76	116.89	65	132.69	172.61	136.31	101.64
152.59	198.50	156.76	116.89	66	132.69	172.61	136.31	101.64
152.59	198.50	156.76	116.89	67	132.69	172.61	136.31	101.64
159.09	206.33	163.72	121.99	68	138.34	179.42	142.36	106.07
165.47	214.36	170.85	127.10	69	143.89	186.40	148.56	110.53
171.65	221.82	177.47	131.92	70	149.26	192.89	154.33	114.71
176.78	229.05	183.89	136.76	71	153.72	199.17	159.91	118.92
181.92	236.27	190.31	141.59	72	158.19	205.46	165.49	123.12
187.05	243.50	196.73	146.43	73	162.65	211.74	171.07	127.33
192.19	250.73	203.15	151.26	74	167.12	218.02	176.65	131.53
197.32	257.95	209.57	156.10	75	171.59	224.31	182.23	135.74
202.12	265.99	216.49	161.52	76	175.76	231.30	188.25	140.45
207.01	274.18	223.54	167.03	77	180.01	238.42	194.39	145.25
212.18	282.79	230.96	172.82	78	184.51	245.91	200.83	150.28
217.46	291.57	238.51	178.73	79	189.09	253.54	207.40	155.41
223.04	300.82	246.46	184.93	80	193.95	261.58	214.31	160.81
227.88	310.18	254.51	191.45	81	198.16	269.72	221.31	166.48
233.04	320.05	262.98	198.31	82	202.64	278.31	228.68	172.44
238.30	330.14	271.64	205.32	83	207.22	287.08	236.21	178.54
243.66	340.45	280.49	212.48	84	211.88	296.04	243.91	184.77
249.12	350.98	289.54	219.81	85	216.63	305.20	251.77	191.14
254.92	361.90	298.82	227.27	86	221.67	314.69	259.84	197.63
260.84	373.10	308.34	234.94	87	226.82	324.44	268.12	204.30
266.90	384.60	318.11	242.82	88	232.08	334.44	276.62	211.14
272.82	396.02	327.83	250.66	89	237.23	344.36	285.07	217.97
278.60	407.32	337.46	258.46	90	242.26	354.19	293.44	224.75
282.78	416.69	345.45	265.05	91	245.89	362.34	300.39	230.48
287.02	426.25	353.59	271.77	92	249.58	370.66	307.47	236.32
290.75	435.14	361.19	278.08	93	252.83	378.38	314.08	241.81
294.53	444.18	368.91	284.51	94	256.11	386.24	320.79	247.40
298.35	453.37	376.77	291.05	95	259.44	394.24	327.62	253.09
304.62	462.89	384.68	297.16	96	264.89	402.51	334.50	258.40
311.02	472.61	392.76	303.40	97	270.45	410.97	341.53	263.83
317.55	482.54	401.01	309.77	98	276.13	419.60	348.70	269.37
324.22	492.67	409.43	316.28	99	281.93	428.41	356.02	275.02

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 5-2020

Thrivent – Monthly $ Premium Rates: **Standard Plans – NONSMOKER** For ZIP codes starting with: **201, 205, 220-225, 237**

MALE				ATTAINED AGE	FEMALE			
Plan A	**Plan F^**	**Plan G**	**Plan N**		**Plan A**	**Plan F^**	**Plan G**	**Plan N**
138.58	180.28	142.37	106.16	65	120.51	156.77	123.80	92.31
138.58	180.28	142.37	106.16	66	120.51	156.77	123.80	92.31
138.58	180.28	142.37	106.16	67	120.51	156.77	123.80	92.31
144.48	187.39	148.69	110.79	68	125.64	162.95	129.30	96.34
150.28	194.68	155.16	115.44	69	130.68	169.29	134.93	100.38
155.89	201.46	161.18	119.81	70	135.56	175.18	140.16	104.18
160.55	208.02	167.01	124.20	71	139.61	180.89	145.23	108.00
165.22	214.59	172.84	128.60	72	143.67	186.60	150.30	111.82
169.88	221.15	178.67	132.99	73	147.72	192.30	155.37	115.64
174.55	227.71	184.50	137.38	74	151.78	198.01	160.44	119.46
179.21	234.28	190.33	141.77	75	155.84	203.72	165.50	123.28
183.57	241.58	196.62	146.69	76	159.63	210.07	170.98	127.56
188.01	249.01	203.03	151.70	77	163.48	216.53	176.54	131.91
192.71	256.83	209.76	156.96	78	167.57	223.33	182.40	136.49
197.50	264.81	216.62	162.32	79	171.74	230.27	188.36	141.15
202.57	273.21	223.84	167.96	80	176.15	237.57	194.64	146.05
206.97	281.71	231.14	173.88	81	179.97	244.97	201.00	151.20
211.65	290.68	238.84	180.10	82	184.04	252.76	207.69	156.61
216.43	299.84	246.71	186.47	83	188.20	260.73	214.53	162.15
221.29	309.20	254.75	192.98	84	192.43	268.87	221.52	167.81
226.26	318.76	262.96	199.63	85	196.74	277.19	228.66	173.60
231.52	328.68	271.39	206.41	86	201.32	285.81	235.99	179.49
236.90	338.86	280.04	213.38	87	206.00	294.66	243.51	185.54
242.40	349.30	288.92	220.53	88	210.78	303.74	251.23	191.76
247.78	359.67	297.74	227.65	89	215.46	312.75	258.90	197.96
253.03	369.93	306.49	234.73	90	220.02	321.68	266.51	204.12
256.82	378.45	313.74	240.72	91	223.32	329.08	272.82	209.32
260.67	387.13	321.14	246.83	92	226.67	336.64	279.25	214.63
264.06	395.20	328.03	252.56	93	229.62	343.65	285.25	219.62
267.49	403.41	335.05	258.39	94	232.60	350.79	291.35	224.69
270.97	411.76	342.19	264.33	95	235.62	358.05	297.55	229.86
276.66	420.40	349.37	269.88	96	240.57	365.57	303.80	234.68
282.47	429.23	356.71	275.55	97	245.63	373.25	310.18	239.61
288.40	438.25	364.20	281.34	98	250.78	381.08	316.70	244.64
294.46	447.45	371.85	287.25	99	256.05	389.09	323.35	249.78

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 5-2020

Thrivent – Monthly $ Premium Rates: **Standard Plans – SMOKER** For ZIP codes starting with: **201, 205, 220-225, 237**

MALE				ATTAINED AGE	FEMALE			
Plan A	**Plan F^**	**Plan G**	**Plan N**		**Plan A**	**Plan F^**	**Plan G**	**Plan N**
159.37	207.32	163.73	122.08	65	138.58	180.28	142.37	106.16
159.37	207.32	163.73	122.08	66	138.58	180.28	142.37	106.16
159.37	207.32	163.73	122.08	67	138.58	180.28	142.37	106.16
166.16	215.50	170.99	127.41	68	144.48	187.39	148.69	110.79
172.82	223.89	178.44	132.75	69	150.28	194.68	155.16	115.44
179.28	231.68	185.36	137.78	70	155.89	201.46	161.18	119.81
184.64	239.23	192.07	142.83	71	160.55	208.02	167.01	124.20
190.00	246.78	198.77	147.88	72	165.22	214.59	172.84	128.60
195.37	254.32	205.47	152.93	73	169.88	221.15	178.67	132.99
200.73	261.87	212.18	157.99	74	174.55	227.71	184.50	137.38
206.09	269.42	218.88	163.04	75	179.21	234.28	190.33	141.77
211.11	277.81	226.11	168.69	76	183.57	241.58	196.62	146.69
216.21	286.36	233.48	174.46	77	188.01	249.01	203.03	151.70
221.61	295.36	241.22	180.50	78	192.71	256.83	209.76	156.96
227.12	304.53	249.11	186.67	79	197.50	264.81	216.62	162.32
232.95	314.19	257.41	193.15	80	202.57	273.21	223.84	167.96
238.01	323.97	265.82	199.96	81	206.97	281.71	231.14	173.88
243.40	334.28	274.67	207.12	82	211.65	290.68	238.84	180.10
248.89	344.81	283.71	214.44	83	216.43	299.84	246.71	186.47
254.49	355.58	292.96	221.93	84	221.29	309.20	254.75	192.98
260.19	366.58	302.41	229.58	85	226.26	318.76	262.96	199.63
266.25	377.98	312.10	237.38	86	231.52	328.68	271.39	206.41
272.43	389.69	322.04	245.38	87	236.90	338.86	280.04	213.38
278.76	401.70	332.25	253.61	88	242.40	349.30	288.92	220.53
284.95	413.62	342.40	261.80	89	247.78	359.67	297.74	227.65
290.98	425.42	352.46	269.94	90	253.03	369.93	306.49	234.73
295.34	435.21	360.80	276.83	91	256.82	378.45	313.74	240.72
299.77	445.20	369.31	283.85	92	260.67	387.13	321.14	246.83
303.67	454.48	377.24	290.44	93	264.06	395.20	328.03	252.56
307.62	463.92	385.31	297.15	94	267.49	403.41	335.05	258.39
311.61	473.52	393.51	303.98	95	270.97	411.76	342.19	264.33
318.16	483.46	401.78	310.37	96	276.66	420.40	349.37	269.88
324.84	493.62	410.22	316.88	97	282.47	429.23	356.71	275.55
331.66	503.98	418.83	323.54	98	288.40	438.25	364.20	281.34
338.63	514.57	427.62	330.33	99	294.46	447.45	371.85	287.25

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 5-2020

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	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 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 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.*