



Thrivent Traditional Long-Term Care Insurance

Product Guide

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Introduction

Thrivent Traditional Long-Term Care Insurance

Thrivent Traditional Long-Term Care Insurance is a comprehensive product that can help clients and prospects pay for qualified long-term care expenses and protect income and savings from being redirected to pay for care.

Thrivent Traditional Long-Term Care Insurance covers services and care in a variety of settings, from home care to facility care, giving the insured flexibility to receive the level of care he or she needs in a location he or she may prefer.

Full Impact of Long-Term Care Needs

On January 1, 2011, the first of 76 million baby boomers started to turn 65, a transition that is reported to continue at a rate of more than 10,000 people per day, every day, for the next 18 years.¹

By 2050, the number of individuals using paid long-term care services in any setting (e.g., at home, residential care such as assisted living, or skilled nursing facilities) will likely double from 13 million in 2000, to 27 million people. This estimate is influenced by growth in the population of older people in need of care.²

Why Thrivent Traditional Long-Term Care Insurance?

We believe long-term care is an event, not a product. You may never experience the need for it, but if you do, the people you love will experience consequences—emotional, physical and financial.

It's critical to make an extended care plan (whether you believe you'll need it or not). With a strategy in place, your family won't have to make hasty, emotional decisions that too often damage family relationships.

Long-term care insurance is a way to fund the choices you specify in your strategy (where/how you'll receive care, your family's involvement, how you'll pay for care).

Caregiving can have a devastating emotional effect on a family. Care coordination services handle the business details, so you can focus on being a family.

As a financial professional, you can help guide your clients throughout their long-term care planning decisions, as part of an ongoing overall financial strategy.

¹"Combination Insurance Products: What Do Consumers Really Want?" Pokorski, Robert M.D. LIMRA's MarketFacts Quarterly/Number 1, 2011.

²U.S. Department of Health and Human Services, and U.S. Department of Labor. The future supply of long-term care workers in relation to the aging baby boom generation: Report to Congress. Washington, D.C.: Office of the Assistant Secretary for Planning and Evaluation, 2003. <http://aspe.hhs.gov/daltcp/reports/lcwork.pdf> (Jan. 20. 2005)

General Overview

What Is Long-Term Care?

Long-term care is a range of services and support that may be needed to meet health or personal needs over a long period of time. Most long-term care is not medical care, but rather assistance with the basic personal tasks of everyday life, called “activities of daily living,” such as:

- Bathing
- Dressing
- Using the toilet
- Transferring (to or from bed or chair)
- Caring for incontinence
- Eating

Many different services help people with chronic conditions overcome limitations that keep them from being independent. Long-term care is different from traditional medical care. Long-term care helps a person live as he or she does now. However, it may not help to improve or correct medical conditions.

Long-term care services that help with activities of daily living may include home health care, respite care, hospice care, adult day care, care in a nursing home and care in an assisted living facility. Long-term care may also include care management services, which will evaluate needs and coordinate and monitor the delivery of long-term care services.

Who May Need Long-Term Care?

The need for long-term care may begin gradually and progress as more and more help is needed with activities of daily living, such as bathing, dressing, household chores, meal preparation or managing money. Or long-term care may be needed suddenly after a major illness, such as a stroke or heart attack. It may also be needed due to injuries sustained in an accident. If care is needed, a stay at a care facility or home health care services may be necessary—for months, years or the rest of a person's life.

What Can Long-Term Care Insurance Do for Clients and Prospects?

Long-term care insurance can help clients and prospects:

- Stay at home longer.
- Pay for qualified long-term care expenses and protect income and savings from being reallocated to pay for care.
- Receive help with activities of daily living. For example:
 - An occupational therapist may be needed to provide instruction on how to use adaptive equipment (such as a reacher, sock aid or long-handled shoe horn) or alternate ways to perform daily activities.
 - A home health aide may help with showers, general hygiene and setting up daily medications.
 - A nurse may be needed to periodically provide assistance with insulin shots, blood thinners, routine vital sign checks or wound care.
 - A speech therapist might teach techniques to help a person swallow more effectively if an individual is experiencing problems eating or drinking.

Target Market and Suitability

Target Market

- Preretired
 - Ages 45-65.
 - Working and saving.
- Goals include:
 - Protecting his or her income and savings.
 - Paying for long-term care expenses without depleting savings or redirecting current income.
 - Having choices and control over who provides care and where.
 - Making decisions today to preserve/ensure options and independence in the future.

Secondary Markets

- Women
 - The vast majority of those needing care are women.
 - Most informal caregivers are women.
- Sandwich generation
 - This generation is trying to manage helping their parents and raising their children.
 - They recognize that their parents may not have planned and may not be able to financially obtain coverage.
 - They may be willing to purchase coverage on their parents so they can manage their care instead of provide it.
- Business owners
 - Appeal as a key person.
 - Potential tax advantages.

Suitability

A person should consider buying long-term care insurance if he or she:

- Has significant savings and income.
- Wants to protect some of the assets and income.
- Can pay premiums, including possible future premium increases, without financial difficulty.
- Wants to stay independent of the support of others.
- Wants the flexibility to choose care in the setting that he or she will be most comfortable in.

A person should not buy long-term care insurance if he or she:

- Cannot afford the premiums.
- Has limited assets, savings or income.
- Only has a single source of income from a Social Security benefit or Supplemental Security Income (SSI).
- Often has trouble paying for utilities, food, medicine or other important needs.
- Is on Medicaid.

There are several long-term care insurance options available to clients, including stand-alone long-term care insurance (like this product), annuities with a long-term care insurance rider, and life insurance with a long-term care insurance rider. Each type of coverage has unique characteristics and features, and—as a result—it is difficult to make “apples-to-apples” comparisons.

Stand-alone long-term care insurance may have a larger benefit over a longer period of time. This type of insurance is also pure insurance.

You can help clients understand the differences and develop insights about which type of coverage may be appropriate for their specific situation. Consider clients' overall financial situations and use available illustrations to highlight the unique product features. (Additional suitability information on page 33.)

Basic Product Overview*

Thrivent Traditional Long-Term Care Insurance is intended to be federally tax-qualified long-term care insurance pursuant to the Internal Revenue Code 7702B(b).

It is a comprehensive long-term care insurance product, with coverage that includes home health care, residential care facilities and adult day care.

Thrivent Traditional Long-Term Care Insurance Benefits

The benefits below are available after the elimination period has been satisfied and are subject to the maximum monthly benefit and available benefit. Benefits may vary by state.

Home Health Care	Home health care benefits are qualified long-term care services if they are: • Necessary to enable the insured to continue to live safely in his or her own residence; and • Are provided by an employee of a home health agency or other trained personnel in the insured's residence. Note: Although family members may be taking care of the insured, family/informal caregivers cannot bill for services to be reimbursed. Home care services include: • Homemaker services. • Home health aide services. • Skilled nursing services. • Nutritional and dietary services. • Physical, occupational, speech and respiratory therapy. • Hospice care services. Homemaker services include the following services when an impairment does not permit a person to perform them and an informal caregiver is not available: • Routine housecleaning. • Preparing meals. • Laundry. • Shopping for essentials.
Residential Care Facility	Residential care facility benefits include nursing homes, assisted living facilities and hospice care. Residential care facilities do not include any facility that is primarily: • A clinic, hospital or sanatorium. • A subacute care or rehabilitation hospital. • A sheltered living accommodation, a residence home or a similar living arrangement. • A home or facility that operates primarily for the treatment of alcoholism, drug addiction or a mental or nervous disorder.
Adult Day Care Facility	Adult day care benefits provide care and companionship, outside the home, to small groups of adults (typically six or more) who are chronically ill and need assistance or supervision during the day. The program offers relief to family members or caregivers and allows them the freedom to go to work, handle personal business or just relax knowing their loved one is well cared for and safe.

*Refer to individual state contracts for unique contractual definitions/terms.

Contract Provisions

Feature	Details	Additional Information
Issue Ages	18 to 79	The age used for the contract is the applicant's age as of 30 days prior to the application date. Example: The applicant's birthday is on Nov. 10 and she turned 60. She applies for a long-term care insurance contract on Nov. 28. In this case, her contract age would be 59 years old, even though her actual age is 60 (30 days prior to Nov. 28 she was 59 years old). "Saving Age" is not allowed, other than as described above.
Risk Classes	Preferred Standard Class 1 Class 2	Preferred—90% of standard. Class 1—125% of standard. Class 2—150% of standard. Gender-distinct pricing (except for Montana).
Premium Payment Types	Lifetime Pay 10 Pay	This is not a cash accumulation product; no cash value is accumulated with limited pay or lifetime pay. Underwriting does not vary based on the premium payment type. Changes to the premium payment type: • May change from limited pay to lifetime pay after issue. – Not subject to underwriting. – Premium calculated based on the original issue age. • May NOT change from lifetime pay to limited pay after issue. • May NOT add/increase any other benefits or riders when a limited pay premium mode is elected. – If the insured wants to add or increase benefits or riders, he or she must go through underwriting and buy a new contract.
Premium Modes	Monthly EFT Quarterly Semiannually Annually	Paying the premium more often than annually will result in higher premiums.

Contract Provisions (continued)

Feature	Details	Additional Information
Rate Guarantee	Five year rate guarantee	The rate guarantee is for five years from the issue date, and applies to the entire contract, including any flexible increase benefit increases that occur during that time. The new premium associated with the flexible increase benefit would be guaranteed for the remaining years of the original five-year rate guarantee. Example of the rate guarantee with the flexible increase benefit: A contract has an issue date of 1/1/13 and an original maximum monthly benefit of \$2,000 and a \$550 annual premium. The rate guarantee is in effect until 1/1/18. On 1/1/14, the insured accepts a flexible increase offer. The new maximum monthly benefit is \$2,100 and the premium is \$585. The new premium of \$585 is guaranteed until 1/1/18 (five years from the original issue date of the contract). On 1/1/15, the insured declines the flexible increase offer. The premium remains \$585, guaranteed to 1/1/18. On 1/1/16, the insured accepts another flexible increase offer. The new maximum monthly benefit is \$2,205 and the premium is \$630. The new premium of \$630 is guaranteed until 1/1/18.
Dividends	Eligible for dividends	Dividends are not guaranteed. Dividends, if payable, will be applied on an annual basis. The only available dividend option is to reduce the premium. • If the dividend exceeds the premium, the amount in excess will be accumulated and applied toward future premiums. • Accumulated dividends will earn 3.5% interest until used to pay any future premiums. • If the dividend is less than the premium, the balance will be billed. • Upon termination of the contract, any remaining accumulated dividends will be paid to the insured or insured's estate, but only to the extent that they do not exceed the sum of premiums paid by the insured and applied to the contract. – The sum of premiums paid does not include premiums waived or reduced by dividends. All distributions of dividends will be taxable and require a 1099.

Couples Discount

Who Qualifies for the Couples Discount?

The couples discount is available to:

- Married couples.
- State partners/civil unions/domestic partners that are named in a valid certificate or license by the state.
- Two individuals living together for at least three years in a committed relationship as partners or family members AND:
 - Are committed to sharing expenses.
 - Are not married.
 - If related, must belong to the same generation (such as siblings).

Why Do ‘Couples’ Receive a Discount?

In general, research has shown that individuals in a committed relationship (such as spouses, partners or family members who live together) provide each other with informal care when it is needed. They tend to use fewer paid care services, and if paid care services are used, they tend to be used later in the process compared to single people who are in a similar situation.

Having a spouse or partner to assist with care can make a significant difference in the type of care needed and where it is received. Care provided in the insured's home is typically less expensive than residential care, thus potentially resulting in lower claim amounts being paid over time.

Two Available Discounts ¹		
Discount	Details	Additional Information
20% Couples Discount ²	• Both individuals apply and are approved for coverage, or • One individual has existing coverage issued by Thrivent, AAL or LB, and the other is applying for Thrivent Traditional Long-Term Care Insurance coverage.	• When one insured dies or if the couple divorces or separates: – Discount remains for life. – No changes to coverage. • Marriage/remarriage (or meets the eligibility rules for the couples discount outlined above): – Discount may be applied after issue if insured marries or remarries and the new spouse buys a contract.
5% Couples Discount ³	• Both individuals apply but only one is approved for coverage; or • Only one individual applies.	• Discount may be applied after issue if the insured marries or remarries (or meets the eligibility rules for the couples discount outlined above). • Do not need to submit two applications to qualify for 5% discount.³

¹All discounts are subject to eligibility rules as explained in this Product Guide.

²For MT: 25% Couples Discount.

³For MT: 10% Couples Discount.

Features and Benefits Overview

Thrivent Traditional Long-Term Care Insurance is a comprehensive product with many built-in features, as well as optional riders to customize the plan according to the client's or prospect's personal needs.

It may be helpful to think about the coverage in four buckets: base contract benefits and features, basic building blocks, inflation protection and optional riders.

- Base contract benefits and features are built into the base contract. A few examples include ancillary benefits, bed reservation, care coordination and waiver of premium.
- The basic building blocks are the required choices an individual must make when designing his or her personal long-term care insurance contract. They include:
 - Maximum monthly benefit amount.
 - Benefit multiplier.
 - Available benefit.
 - Elimination period.
- We offer two benefit increase options to help keep pace with inflation and the rising costs of care:
 - Flexible Increase Benefit.
 - › 5% compound
 - Annual Increase Benefit.
 - › 1% compound
 - › 2% compound
 - › 3% compound
 - › 5% compound
- Optional riders are typically the last choices to be made. They are available for an additional cost and customize the long-term care insurance contract to meet an individual's specific wants and needs. The optional riders are:
 - Waiver of Elimination Period for Home Care and Adult Day Care.*
 - Cash Benefit.
 - Return of Premium Upon Death.
 - Shared Care Benefit.
 - Survivorship Benefit.
 - Nonforfeiture Benefit.

*CA Rider: Waiver of Elimination Period for Home and Community-Based Care.

Base Contract Features and Benefits

Base Contract Features and Benefits	
Waiver of Premium	This benefit states that premiums will be waived once the elimination period is satisfied as long as the insured continues to be benefit-eligible. Once the insured is no longer benefit-eligible and no longer receiving services, the waiver of premium benefit will end and premium payments will resume. If the insured becomes eligible for benefits again, the waiver of premium benefit will apply again. Additional Information: • Ancillary benefits do not trigger waiver of premium. • Double waiver of premium is included if the insured has the shared care benefit rider. – This will waive the premium for both individuals even if only one insured is receiving benefits. • Limited Pay Contracts: – If the contract goes on waiver for a limited pay contract, it does not change the number of years the premium will be paid. Example: The payment type selected on a contract is 10 years. If the individual pays the premium for five years and then goes on premium waiver for two years and then recovers, he or she would need to pay the remaining three years of premium payments.
Contingent Nonforfeiture Benefit—Lifetime Pay Contracts	This benefit states that if the contingent nonforfeiture benefit is triggered, the coverage will continue as paid-up coverage. If the benefit is triggered by premium default, the paid-up coverage will be effective on the date the grace period ends. Otherwise, paid-up coverage will be effective the date of the insured's notice to cancel the contract. • Benefits will be paid subject to all of the conditions and limitations of this contract. • Maximum monthly benefit and elimination period will be the same as were in effect at the time of lapse. • No increases will be provided under any increase benefit rider on or after the date paid-up coverage becomes effective. • All riders on this contract will terminate on the date paid-up coverage becomes effective. • The available benefit under the paid-up coverage may be used for all care and services covered under the terms of the contract. • The available benefit will be reduced by the amounts that are paid under the paid-up coverage. • Paid-up coverage will terminate on the date the available benefit reaches zero. The paid-up coverage will have an available benefit equal to the lesser of: 1. The nonforfeiture credit. 2. The available benefit in effect immediately before the date paid-up coverage becomes effective. The nonforfeiture credit is equal to the greater of: 1. The total of all premiums paid for the contract. 2. The maximum monthly benefit in effect on the date paid-up coverage becomes effective. Premiums paid by the insured do not include premiums waived by Thrivent or reduced by dividends. The Contingent Nonforfeiture Benefit will be triggered if: 1. Thrivent increases the premium rates; 2. The new premium represents a substantial increase in premium;* and 3. Within 120 days after the due date of the new premium if either: a. The contract terminates due to premium default; or b. The insured gives notice to cancel the contract. The date of notice is the date Thrivent receives it or, if later, the date the insured specifies. *A substantial premium increase is an increase that results in a cumulative percentage increase in premiums since the contract's date of issue that equals or exceeds the percentages shown in Appendix A.

Base Contract Features and Benefits Continued

Contingent Nonforfeiture Benefit— Limited Pay Contracts

This benefit states that if the contract has a limited premium payment period, and the contingent nonforfeiture benefit is triggered, the coverage will continue as paid-up coverage with reduced benefit maximums. If the benefit is triggered by premium default, the paid-up coverage will be effective on the date the grace period ends. Otherwise paid-up coverage will be effective the date of the insured's notice to cancel the contract.

- Benefits will be paid subject to all of the conditions and limitations of the contract.
- No increases will be provided under any increase benefit rider on or after the date paid-up coverage becomes effective.
- All riders on the contract will terminate on the date paid-up coverage becomes effective.
- The available benefit under the paid-up coverage may be used for all care and services covered under the terms of the contract.
- The available benefit will be reduced by the amounts that are paid under the paid-up coverage.
- Paid-up coverage will terminate on the date the available benefit reaches zero.

The contract's remaining available benefit, maximum monthly benefit and ancillary benefit limits will be reduced to amounts equal to:

$$\begin{array}{r} 90\% \text{ of the amounts in effect prior to termination} \\ \times \\ \# \text{ of months premiums were paid} / \# \text{ of months in the premium paying period} \\ = \\ \text{Paid-up benefit amount} \end{array}$$

Premiums paid by the insured do not include premiums waived by Thrivent or reduced by dividends.

The Limited Premium Payment Period Contingent Nonforfeiture Benefit will be triggered if:

1. Thrivent increases the premium rates,
2. The new premium represents a substantial premium,*
3. Prior to the due date of the increased premium, premiums have been paid for at least 40% of the number of months in the premium payment period, and
4. Within 120 days after the due date of the new premium if either:
 - a. The contract terminates due to premium default, or
 - b. The insured gives notice to cancel the contract. The date of notice is the date Thrivent receives it or, if later, the date the insured specifies.

*A substantial premium increase is an increase that results in a cumulative percentage increase in premiums since the contract's date of issue that equals or exceeds the percentages shown in Appendix A.

Base Contract Features and Benefits Continued

Alternate Care Benefit	Allowing for an alternate care benefit helps ensure that individuals have access to emerging services that may develop over time, but are not currently identified or available. This allows the insured to qualify for benefits not specifically listed elsewhere in the contract. Alternate care that is not normally covered by the contract may be covered if: • Thrivent and the insured have a written agreement that describes how the services will be covered. • The alternate care is prescribed in a plan of care document. – The care is a cost-effective alternative. – The plan pays expenses up to the maximum monthly benefit. – Care is subject to the elimination period and available benefit. Benefits will be paid according to the terms of the contract (e.g., maximum monthly benefit, available benefit). No benefits will be paid for alternate services provided prior to the date of the agreement.
Bed Reservation	This feature provides a benefit for bed reservation for temporary absences of up to 60 days per calendar year. This means that if the insured is in a residential care facility and temporarily leaves (e.g., to go to the hospital or attend a family event), the charges incurred to hold a space to enable the insured to return to that facility will be covered. If the elimination period has not yet ended, the crediting of days toward the elimination period will not be interrupted by a temporary absence as described above.
Care Coordinator Services	If the insured would like to use the services of a care coordinator, Thrivent will identify someone in the area. The insured is not required to use care coordinator services in order to use his or her insurance benefits. Expenses for care coordinator services will not be reimbursed from the contract coverage but rather are covered separately by Thrivent. A care coordinator can help develop the insured's required plan of care, which will be used to administer benefits. A care coordinator is a health care professional with training and expertise in case management. Services provided by a care coordinator include: • Performing a comprehensive care needs assessment. • Developing, implementing and coordinating a plan of care. • Identifying the services needed. • Locating local caregivers and care facilities. • Monitoring ongoing care.

Ancillary Benefits

Ancillary Benefits*

Ancillary benefits include:

- Respite care.
- Equipment/home modification.
- Caregiver training.
- International care benefit.

These benefits are not subject to the elimination period or the maximum monthly benefit. In addition, the benefits do not satisfy the elimination period. Ancillary benefits that are paid will reduce the total available benefit amount.

Each ancillary benefit has its own separate benefit limit. The benefit limits are tied directly to the maximum monthly benefit. If the maximum monthly benefit increases or decreases, so do the ancillary benefit limits.

Ancillary benefits = 2x maximum monthly benefit.

Example: The insured has a \$5,000 maximum monthly benefit amount, a 60-month benefit multiplier and the 5% compound annual increase benefit. The available benefit is \$300,000 ($\$5,000 \times 60 = \$300,000$).

The ancillary benefit limits would be \$10,000 when the contract is issued ($2 \times \$5,000 = \$10,000$).

After the first contract anniversary when the 5% compound annual increase benefit is applied, the maximum monthly benefit would be \$5,250 and the available benefit would be \$315,000. Thus, the ancillary benefit limits would be \$10,500.

If \$2,000 is paid for respite care in the second contract year, the available benefit amount would be reduced to \$313,000 ($\$315,000 - \$2,000 = \$313,000$). The remaining respite care benefit for that contract year would be \$8,500 ($\$10,500 - \$2,000 = \$8,500$).

*For CA: Referred to as Supplemental Benefits. Respite care is the only ancillary benefit that is available each calendar year. Equipment/home modification, caregiver training and the international care benefit are lifetime limits.

Respite Care Benefit

Respite care is designed to provide an opportunity for an informal caregiver to have some needed time off by providing alternative care for the insured.

Respite care means qualified long-term care services are designed to:

- Relieve an informal caregiver.
- Provide on a short-term basis, in a residential care facility, an adult day care facility, or in a person's home as home care services.
- Are received in a week where no days are credited toward the elimination period.
 - The insured must decide if the days go toward the elimination period or toward respite care benefits (cannot do both in the same week).

Benefit = 2x current maximum monthly benefit amount each calendar year.

Ancillary Benefits Continued

Equipment/Home Modification Benefit	Equipment/home modifications are safety-related alterations to the home. Equipment or home modifications must be specified in the plan of care and be necessary according to the insured's condition to be covered. Special equipment means: • Therapeutic equipment such as a hospital bed, wheelchair, crutches or walker. • Safety-related equipment such as a medical alert system. • Any other medical equipment that is specified in the insured's plan of care. Home modifications are: • Home safety checks to evaluate the insured's home to determine if it is a physically safe environment for the insured and provide recommendations for home modifications. • Accessibility changes to an insured's home such as a ramp, chairlift or alterations to accommodate a wheelchair. • Safety-related changes to an insured's home such as installation of grab bars or railings. • Any other changes to an insured's home that are specified in his or her plan of care. Benefit = 2x current maximum monthly benefit amount (lifetime limit).
Caregiver Training Benefit	The caregiver training benefit allows a qualified health care professional to provide training that is specific to the needs of the insured so that an informal caregiver can care for that person. An informal caregiver does not receive compensation for providing care. Benefit = 2x current maximum monthly benefit amount (lifetime limit).
International Care Benefit	The international care benefit provides a nominal benefit if covered services are received outside of the United States, its territories and possessions. The international care benefit can be used for: • Nursing home care. • Assisted living care. • Home health care. • Hospice care. The insured must provide appropriate documentation in English to receive payment. This documentation includes: • Certification from a U.S.-licensed health care practitioner that the insured is chronically ill and received care for the covered expense for which the insured is submitting notice of claim. • Properly completed claim forms and proof that the insured is receiving covered care (in the form of fully itemized bills). • Copy of an airline ticket or other proof acceptable that the insured is outside of the country. • Copies of medical records which Thrivent deems necessary to support the insured's claim. The benefit is paid in U.S. dollars to the insured. The benefit will not cover expenses incurred in countries where payment would violate economic, financial or trade sanctions imposed by the U.S. or United Nations. Benefit = 2x current maximum monthly benefit amount (lifetime limit). Cash Benefit Rider does not pay when receiving international care.

Basic Building Blocks

The basic building blocks are the required choices individuals must make when you are helping design his or her long-term care insurance and include:

- Elimination period.
- Benefit multiplier.
- Maximum monthly benefit.
- Available benefit.

Basic Building Block	Details	Additional Information
Elimination Period	30, 90 or 180 days*	The elimination period is the time when the insured must pay for covered services before the insurance begins paying benefits. Calendar days: • One day of service in a week receives credit for full week (seven days). • Calendar week begins on Sunday and ends Saturday. The elimination period needs to be satisfied only once while the contract is in force. Changes to the elimination period: • Decreases—Changing to a longer elimination period after issue. – Subject to the current issue minimums. – Future premium will be recalculated based on the decreased coverage and the original issue age. – Cannot decrease coverage during or after a claim period has occurred. • Increases—Changing to a shorter elimination period after issue. – Subject to underwriting at attained age. Note: Zero-day elimination is an option for the home care and adult day care benefit only if the optional waiver of elimination period for home care and adult day care rider is selected.
Benefit Multiplier	24, 36, 48, 60 or 96 months	The benefit multiplier is a factor based on time (expressed in months) that is used to determine the insured's available benefit or pool of money. Changes to the benefit multiplier: • Decreases—Can be decreased after issue. • Increases—Can be increased after issue. – Subject to evidence of insurability. Example: If the insured selects a \$5,000 maximum monthly benefit and a 60-month benefit multiplier, the total available benefit is \$300,000 for long-term care expenses, regardless of how long it takes to use the benefits. • $\\$5,000 \times 60 = \\$300,000$ If the insured uses the maximum every month, benefits will last approximately five years. Benefit increase options, which are discussed later in the guide, would extend the time frame that the benefit would be paid. If less than the maximum is used, the available benefit will last longer than five years.

*CT: 180 days Elimination Period is not available.

Basic Building Blocks Continued

Basic Building Block	Details	Additional Information																								
Maximum Monthly Benefit	\$1,500–\$15,000 (Increments of \$100)	The maximum monthly benefit amount is the limit on the amount the contract would pay, each month, during a claim period for qualified expenses. The elimination period must be met and there must be a remaining available benefit. Changes to the maximum monthly benefit: • Decreases—Can be decreased after issue. • Increases—Can be increased after issue. – Subject to evidence of insurability. Examples: • If expenses in a given month during a claim period exceed the contract's benefit amount, the expenses would be reimbursed up to the maximum monthly benefit amount and reduce the total available benefit. • If expenses in a given month during a claim period are less than the contract's maximum monthly benefit amount, the expenses would be reimbursed, and the unused portion of the maximum monthly benefit amount would remain in the total available benefit. The total available benefit would be reduced only by the amount reimbursed. – The unused maximum monthly benefit does not increase the following month's maximum monthly benefit amount. It does help the pool of money last longer. • The chart below shows how a hypothetical claim may be paid based on a \$5,000 maximum monthly benefit and total available benefit of \$300,000. <table><tr><th></th><th>Long-term care expense incurred</th><th>Actual amount paid from long-term care insurance contract</th><th>Available Benefit</th></tr><tr><td>January</td><td>\$2,500</td><td>\$2,500</td><td>\$297,500</td></tr><tr><td>February</td><td>\$3,000</td><td>\$3,000</td><td>\$294,500</td></tr><tr><td>March</td><td>\$5,000</td><td>\$5,000</td><td>\$289,500</td></tr><tr><td>April</td><td>\$5,200</td><td>\$5,000</td><td>\$284,500</td></tr><tr><td>May</td><td>\$4,800</td><td>\$4,800</td><td>\$279,700</td></tr></table>		Long-term care expense incurred	Actual amount paid from long-term care insurance contract	Available Benefit	January	\$2,500	\$2,500	\$297,500	February	\$3,000	\$3,000	\$294,500	March	\$5,000	\$5,000	\$289,500	April	\$5,200	\$5,000	\$284,500	May	\$4,800	\$4,800	\$279,700
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May	\$4,800	\$4,800	\$279,700																							
Available Benefit		The available benefit is the total pool of money available during the insured's lifetime to pay for qualified long-term care expenses. Monthly Benefit X Benefit Multiplier = Available Benefit Example: The maximum monthly benefit amount selected is \$5,000. The benefit multiplier selected is 60 months. So, the available benefit is \$300,000. \$5,000 x 60 = \$300,000 This amount will increase if the contract has an annual increase benefit or the flexible increase benefit (and does not decline an increase offer). The available benefit is decreased when covered expenses are reimbursed.																								

Benefit Increase Options

If you've seen recent cost-of-care projections, you know long-term care expenses are likely to be higher in the future than they are today. Benefit increase options help protect against the rising costs of long-term care by helping the insureds to customize their plans to meet their current and potential future needs for increased coverage. Choosing a benefit increase option can be one of the most important additions a prospective insured includes in long-term care insurance planning.

Thrivent offers two types of benefit increase options:

- Flexible Increase Benefit (FIB).
- Annual Increase Benefit (AIB).

Benefit increase options:

- Can be added to individual and shared care contracts.
- Cannot be selected together on a contract—can only have one or the other.
- Both options are available on preferred, standard, class 1 and class 2 contracts.

Let's take a closer look at how these options work.

Flexible Increase Benefit (FIB)	
Details	Issue ages: 18 to 70 The flexible increase benefit includes an automatic claim increase benefit.
How It Works	Provides an opportunity to increase the maximum monthly benefit and current remaining available benefit on the contract anniversary by 5% compounded annually. Ancillary benefits will also increase accordingly. • Without evidence of insurability. • All-or-nothing offer each year (5% increase or 0% increase). The increase will be automatic unless the insured opts out when he or she receives the annual notification letter. • Premiums will increase with each offer accepted and premiums will be based on the insured's age at the time of the increase. • Premiums will remain unchanged if the insured does not accept the increase. Automatic increases will occur if the insured is on claim. • The insured can decline automatic increases while on claim, but it may not be in his or her best interest. • If the insured recovers, he or she will have to pay the increased premium amount associated with the new coverage. • If the new premium associated with the automatic increases is not affordable to the insured, the insured can decrease coverage. If three consecutive offers are declined, no future increase offers will be extended. However, the rider will remain on the contract since the insured is still eligible for the automatic claim increases.
Additional Information	This benefit is not available with: • 10-pay contracts. • Survivorship Benefit Rider. Flexible increase benefit increases occur automatically on the contract anniversary. A notification letter will be sent prior to the contract anniversary.
Changes	Changes: • If the flexible increase benefit is dropped after issue, the previous increases will be maintained, and the future premium will be recalculated without the flexible increase benefit rider load/premium. • Flexible increase benefit can be added after issue. – Evidence of insurability will be required.

Flexible Increase Benefit

Let's look at a hypothetical example using the flexible increase benefit:

Mary, at age 50, purchased Thrivent Long-Term Care Insurance, choosing the optional flexible increase benefit rider to help manage her budget. Having the option to accept or decline the premium increases was important to her, especially during the years when her children needed help paying for college. Mary also knew that in preparing for the future, she wanted the maximum monthly benefit amount to increase over time; with a goal to accept increases until her maximum monthly benefit amount reached at least \$15,000.

Over the next 20 years, Mary accepted 13 annual increase offers, and declined seven. However, she didn't decline the offer in three consecutive years, which meant her flexible increase benefit was offered each year.

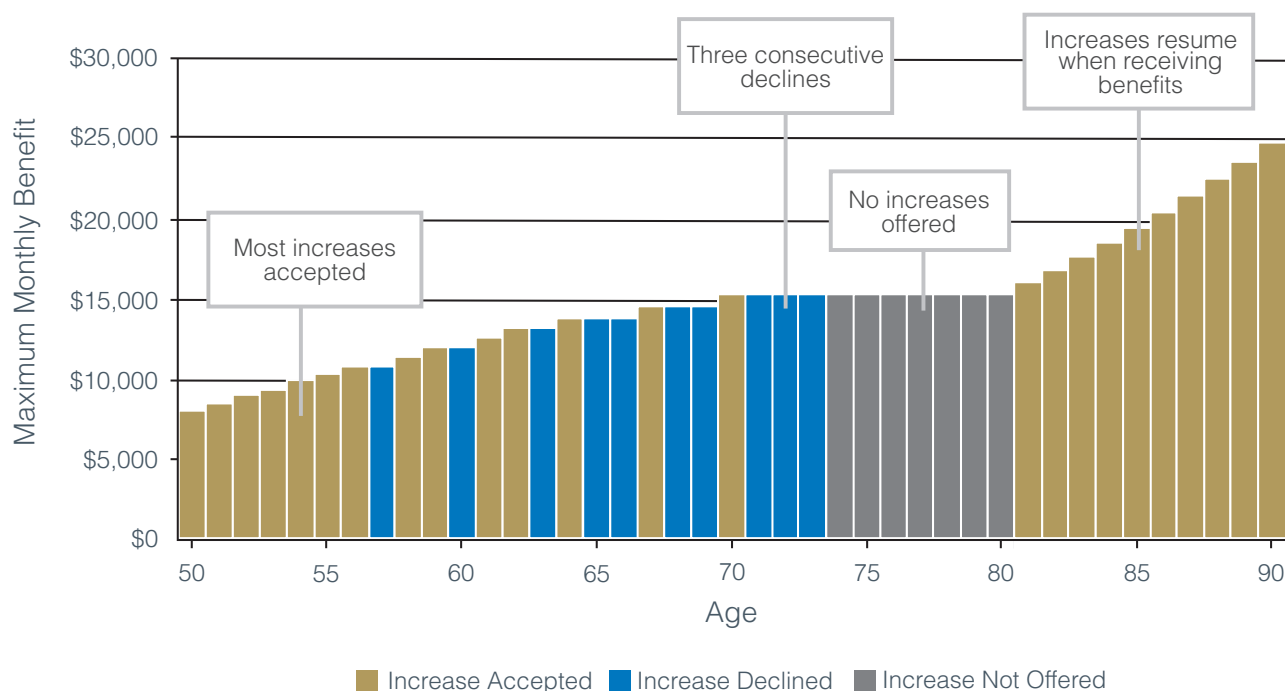
When she reached age 70, Mary decided her maximum monthly benefit of \$15,000 was adequate to meet her needs and declined all future increases. After Mary declined the increase offer three years in a row, she was not offered any future increases.

At age 80, Mary's health declined, and she needed assistance with daily activities. She began to receive qualified long-term care services at home according to her Plan of Care. After meeting her elimination period, her long-term care insurance benefits started.

Now that Mary is on claim, the flexible increase benefit rider automatically increases her maximum monthly benefit and available benefit by 5%, compounded annually, and will continue to do so each year while she is receiving care.

Mary doesn't have to worry about paying premiums during this time since the premium waiver benefit is a standard benefit included with her insurance.

Flexible Increase Benefit Hypothetical Example



Annual Increase Benefit (AIB)

Details	Issue ages: 18 to 79
How It Works	If the insured chooses this benefit rider, the maximum monthly benefit, available benefit (pool of money) and ancillary benefits will automatically increase annually on the rider anniversary, depending on the level selected. Premiums, however, will remain level over time. That's because the cost of future increases is automatically built into the premium. As a result, this benefit may be appropriate for people who want the convenience of making one decision and not having to decide each year or prefer a level premium for budgeting purposes. Four choices are available (compounded annually): • 1% • 2% • 3% • 5%
Changes	• If the annual increase benefit is dropped after issue, the previous annual increases will be maintained and the future premium will be recalculated based on the current amount of maximum monthly benefit coverage (including increases) at the original issue age without the annual increase benefit rider. • The compound annual increase benefit can be decreased after issue. – Allowed decreases include: › Changing from a higher percent AIB to a lower percent AIB (for example: 5% to 3%, 2%, or 1% AIB; 3% to 2% or 1% AIB, or 2% to 1% AIB). – No evidence of insurability required. › Changing from either AIB (5%, 3%, 2% or 1%) to FIB. – No evidence of insurability required. • The compound annual increase benefit can be added or increased after issue. – Evidence of insurability will be required. – Allowed additions and increases include: › Changing from no annual increase benefit to 1%, 2%, 3% or 5%. › Changing from a lower percent AIB to a higher percent AIB (1% to 2%, 3% or 5% AIB; 2% to 3% or 5% AIB; 3% to 5% AIB). › Changing from FIB to AIB.

Annual Increase Benefit

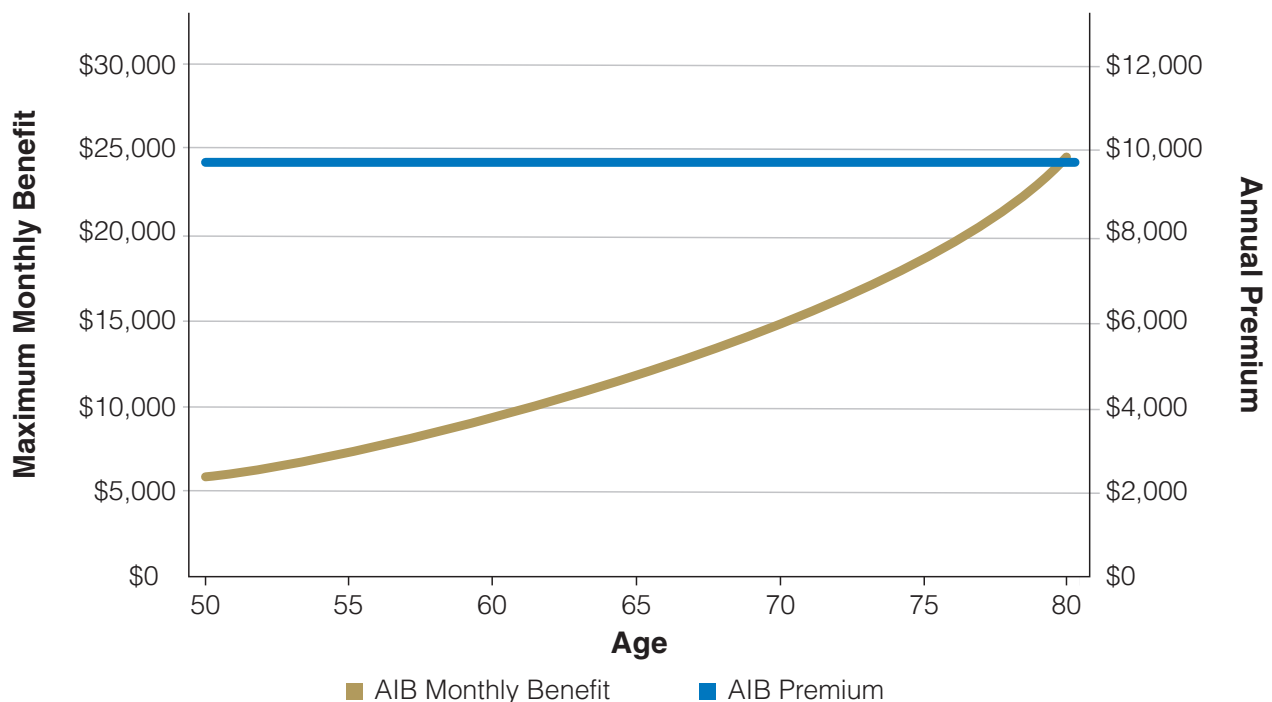
Let's look at a hypothetical example using the 5% annual increase benefit.

At age 50, Sue purchases Thrivent Long-Term Care Insurance with a maximum monthly benefit amount of \$5,700 and a 5% annual increase benefit, compounded annually. Her desired goal is to have a maximum monthly benefit of \$15,000 when she reaches age 70.

As you can see from the chart below, Sue's annual premiums of \$9,638 remain level over time, although her monthly benefit increases 5% annually.

At age 70, Sue's maximum monthly benefit has reached \$15,124, and at age 80—when she needs residential care—her maximum monthly benefit has grown to \$24,635.

Annual Increase Benefit Hypothetical Example*



*Based on a 5% Annual Increase Benefit (compounded annually), \$9,638 annual premium, goal to reach a maximum monthly benefit of \$15,000 by age 70, issue age 50, standard risk class, ignores any other riders and premium discounts that may be applicable. No changes are made to the contract throughout the years illustrated and no claims are paid. Premiums may increase after the initial five year rate guarantee.

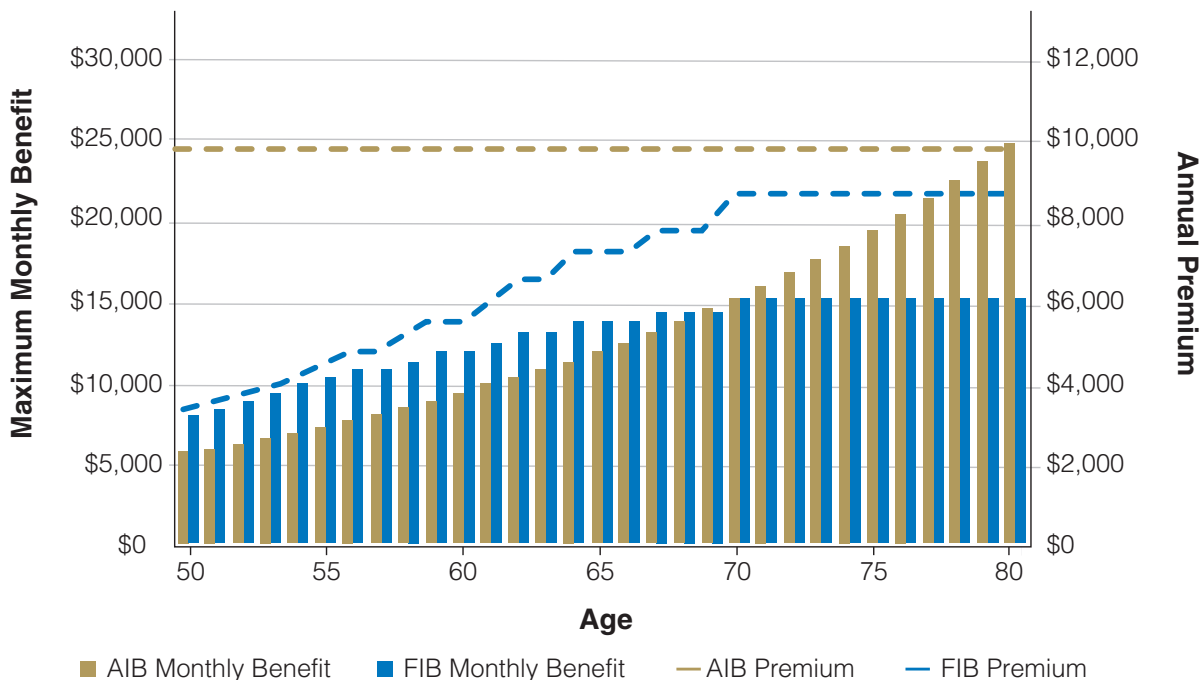
Comparing the Benefit Increase Options

Flexible Increase Benefit	Annual Increase Benefit
• Flexible. • Benefits and premium increase automatically each year unless declined. • For people who prefer a lower initial premium.	• For people who prefer a level premium. • Convenience of making the decision once instead of each year.

The graph below shows a comparison of the maximum monthly benefit and premium between the flexible increase benefit and the annual increase benefit.

This hypothetical comparison is based on the previous examples used for the flexible increase benefit and the annual increase benefit:

- 50-year-old female insured with standard risk class, no couples discount or additional riders.
- 90-day elimination period with 60-month benefit multiplier.
- Goal is to have approximately \$15,000 maximum monthly benefit by age 70.
- Annual increase benefit contract (5%).
 - Maximum monthly benefit amount begins at \$5,700.
 - Annual premium is \$9,638.
- Flexible increase benefit contract.
 - Maximum monthly benefit amount begins at \$8,000.
 - Annual premium is \$3,256.
 - 7 of 20 increases are declined between the ages of 50 and 70.
 - No increases accepted after age 70.



Optional Riders

Optional riders are typically the final choices to be made. They are available for an additional cost and help customize the long-term care insurance contract to meet the individual's specific wants and needs.

The available riders are:

- Waiver of Elimination Period for Home Care and Adult Day Care.*
- Cash Benefit.
- Return of Premium Upon Death.
- Shared Care Benefit.
- Survivorship Benefit.
- Nonforfeiture Benefit.

Waiver of Elimination Period for Home Care and Adult Day Care*

Description	The rider allows the insured to receive home health care and adult day care services on day one—effectively a zero-day elimination period—specifically for at-home care.
How It Works	The coverage days received under this benefit will be applied toward meeting the elimination period (so when facility care is needed, the elimination period doesn't "start over"). Even though the elimination period is waived, the premium will not be waived until the elimination period is met.
Additional Details	Available on individual and shared care contracts. Restriction: This rider is NOT available with the 180-day elimination period.
Changes	• Can be dropped after issue. • Can be added after issue. • Subject to evidence of insurability.

Cash Benefit

Description	The cash benefit is a rider that provides additional cash payments above the maximum monthly benefit, regardless of whether the insured is receiving home care or facility care. It provides the insured with added flexibility to pay for services that are not typically covered.
How It Works	If the insured is receiving home care services: • An additional amount equal to 15% of the maximum monthly benefit would be paid as a cash payment. If the insured is receiving facility care: • The cash benefit is equal to 10% of the maximum monthly benefit. The insured must meet the elimination period and receive at least five days of care per calendar month to receive the benefit. The cash benefit is not payable for international care.
Additional Details	Available on individual and shared care contracts. This benefit is a separate benefit and does not reduce the available benefit. Elimination period must be met before this benefit will be paid. If home care and facility care services are paid in the same month, the higher percentage will be paid. Benefits received may be taxable.
Changes	• Can be dropped after issue. • Can be added after issue. – Subject to evidence of insurability.

*CA Rider: Waiver of Elimination Period for Home and Community-Based Care.

Optional Riders Continued

Return of Premium Upon Death	
Description	This rider returns the premiums paid to the insured's estate at the time of death.
How It Works	The rider must be in force for 10 years before a death occurs to be eligible for payment. Payment = Premiums paid for the base contract and riders less Any accumulated dividends paid upon death and the sum of any benefit payments that were paid on the contract, including ancillary benefits. If the benefits paid exceed premiums paid, then no return of premium is paid. To pay the benefit under this rider, Thrivent requires: • Rider must be active; and • Proof of death; and • Written notice from a representative of the insured's estate that no expenses eligible for payment are outstanding.
Additional Details	Restriction: Only available on individual contracts; not available with shared care contracts. The sum of premiums paid does not include premiums waived or reduced by dividends. May have tax implications for the estate.
Changes	• Can be dropped after issue. • Can NOT be added after issue.
Shared Care Benefit	
Description	This rider is for couples who purchase identical Thrivent Long-Term Care Insurance. It's designed to provide couples with extra flexibility in their long-term care planning.
How It Works	"Benefit partner" is the term used to identify the two people in a shared care benefit agreement. The shared care benefit links two individual contracts together. If an insured uses his or her entire available benefit, then he or she can start drawing from the benefit partner's remaining available benefit. • An insured does not need to satisfy a new elimination period to use his or her benefit partner's benefits since he or she already met the elimination period under his or her own contract. • If one insured qualifies for the waiver of premium, neither benefit partner will have to pay premiums. The joint waiver of premium benefit automatically kicks in. • If an insured uses all of his or her benefit partner's benefits, the benefit partner not on claim can elect to purchase an additional 24-month benefit for his or her use only (without additional underwriting). This is called the residual benefit.¹ • Other than reducing the contract's available benefit, payment of benefits to the benefit partner will not affect the other insured's eligibility for benefits under his or her contract. • Both insureds may be on claim at the same time.

¹In Arizona and Connecticut, each person must retain 24 months of benefits in the pool for the contract owner's sole purpose. The additional 24-month benefit is not available for purchase.

Optional Riders Continued

Shared Care Benefit—Continued	
Additional Details	Both contracts MUST have identical coverage, issue dates and benefits, including: • Elimination period • Benefit multiplier • Maximum monthly benefit • Benefit increase options • Riders • Premium payment type (lifetime pay or limited pay) For contracts with the flexible increase benefit rider: • Benefit partners must either accept or decline the increase offers together—the maximum monthly benefit amounts must be identical at all times. • If one insured is on claim and the other insured is not, both individuals will get the automatic increase associated with the flexible increase benefit. – If the insured that is on claim recovers, both individuals will need to pay for the increases that occurred while on claim. – If the premium associated with the increase in coverage is not manageable, the benefit partners are allowed to drop their coverage amounts (benefits must remain identical). Restrictions: The shared care benefit is not available with the return of premium upon death rider.
Residual Benefit	As mentioned above the residual benefit is available to a contract owner when his or her benefit partner has used all the benefits from both contracts. The benefit partner not on claim can elect to purchase an additional 24-month benefit for his or her use only. The new available benefit will be the current maximum monthly benefit on the date of termination with a benefit multiplier of 24 months. • No evidence of insurability is required. • The new premium will be based on the insured's attained age. • Available through age 85. Eligibility for the residual benefit: • Insured that is applying for the benefit has not had any days credited to his or her elimination period. • Insured that is applying has not been eligible to be certified as chronically ill in the two years before the application date for the residual benefit.
Who can elect the shared care benefit?	The shared care benefit rider is available to: • Married couples. • State partners/civil unions/domestic partners that are named in a valid certificate or license by the state. • Two individuals living together for three consecutive years in a committed relationship as partners or family members AND: – Are committed to sharing expenses. – Are not married. – If related, must belong to the same generation (such as siblings).

Optional Riders Continued

Shared Care Benefit—Continued	
Death, Divorce or Separation	Death - Surviving benefit partner's contract will be automatically increased by the remainder of the deceased's available benefit. - Shared care rider will terminate. - The new premium calculation will be the surviving contract holder's original premium (with the couples discount still in place) less the premium for the shared care rider. There is no charge for the increased available benefit. Example: \$500,000 total shared pool of money at time of initial purchase  \$250,000 \$250,000 Death occurs: Person A dies without using any long-term care benefits  \$250,000 \$250,000 Person B now has the sum of both pools for covered long-term care expenses  \$500,000 Divorce or Separation Upon divorce or separation, this rider is only terminated if one of the benefit partners cancels the rider. Otherwise, the rider will continue. Remarriage/New Partner/New Committed Relationship (See page 24 for who is eligible to elect the shared care benefit.) The insured cannot add a new spouse, partner or family member to this coverage (the rider cannot be added after issue).
	Changes - Can be dropped after issue. - Can NOT be added after issue. - Contract changes cannot be made that create unequal benefits while maintaining the shared care benefit rider. - Example: If benefit partner A wants to drop his or her maximum monthly benefit from \$5,000 to \$3,000, then benefit partner B must do the same. - If a contract change is made that creates an unequal benefit, the shared care benefit rider will be terminated.

Let's take a look at how the shared care benefit rider would work:

In the example below, Paul and Mary have identical Thrivent Traditional Long-Term Care Insurance plans without the shared care benefit rider.

Paul	Mary
Maximum Monthly Benefit \$6,000	Maximum Monthly Benefit \$6,000
Benefit Multiplier 60 months	Benefit Multiplier 60 months
Total Available Benefit is \$360,000 each	

Now, let's take a look at the options Paul and Mary have available to them when they purchase identical Thrivent Traditional Long-Term Care Insurance with the shared care benefit rider:

Paul	Mary
Maximum Monthly Benefit \$6,000	Maximum Monthly Benefit \$6,000
Benefit Multiplier 60 months	Benefit Multiplier 60 months
Total Available Benefit \$360,000	Total Available Benefit \$360,000
Total Available Benefit is \$720,000, which is available to Paul and/or Mary	

Optional Riders Continued

Survivorship Benefit	
Description	This rider states if two individuals (benefit partners) have in-force contracts and riders for 10 years and one individual dies, the surviving benefit partner's contract will become paid up.
How It Works	If two individuals have in-force contracts with the survivorship rider on both of their contracts (naming each other as the benefit partner), then upon the death of one insured, the surviving benefit partner's contract will become paid up. • If either benefit partner dies before 10 years, then no benefit will be paid. • No benefits can have been paid during the first 10 years in force.
Additional Information	The survivorship benefit is available to individuals who qualify for the couples discount (see below for eligibility). The insured's contracts do not need to be identical, but they both have to have the rider and be named as the benefit partner on the other insured's contract. Restriction: This rider is not available with: • 10-pay contracts. • FIB Rider.
Who is eligible for this rider?	The survivorship benefit rider is available to: • Married couples. • State partners/civil unions/domestic partners that are named in a valid certificate or license by the state. • Two individuals living together for three consecutive years in a committed relationship as partners or family members AND: – Are committed to sharing expenses. – Are not married. – If related, must belong to the same generation (such as siblings).
Divorce	Upon divorce/separation, the rider is terminated if one of the insureds cancels the rider; otherwise the rider will continue.
Changes	• Can be dropped after issue. • Can NOT be added after issue.

Optional Riders Continued

Nonforfeiture Benefit	
Description	This rider provides an option for the long-term care benefits to continue as reduced paid-up insurance if the insured chooses to terminate his or her contract for any reason. The contract must be in force for a minimum of three years before this benefit can be triggered.
How It Works	The amount of paid-up coverage will be equal to the lesser of: • The nonforfeiture credit (see below); and • The available benefit in effect immediately before the date paid-up coverage becomes effective.* The nonforfeiture credit is equal to the greater of: • The total premiums paid for the contract; and • The maximum monthly benefit in effect on the date the paid-up coverage becomes effective. Premiums paid by the insured do not include premiums waived by Thrivent or reduced by dividends. The shortened benefit period is NOT reduced by any benefit payments paid prior to the date of lapse but is subject to the remaining available benefit. The same maximum monthly benefit amount, elimination period and other limits (except available benefit) remain that were in effect at the time of lapse. All optional riders will terminate on the date paid-up insurance becomes effective. *For CA: Three times the maximum monthly benefit in effect on the date the paid-up coverage becomes effective.
Additional Information	Available on individual and shared care contracts. If this rider is selected, the insured may also have a contingent nonforfeiture option available BUT the insured can only be paid under one of the nonforfeiture options. The insured may choose which nonforfeiture benefit he or she would like to receive if more than one is triggered.
Changes	• Can be dropped after issue. • Can NOT be added after issue.

Optional Riders Compatibility Chart

This chart shows the allowable combinations of the optional riders and limited pay period options.

	Annual Increase Benefit	Flexible Increase Benefit	Nonforfeiture Benefit	Return of Premium Upon Death	Cash Benefit	Waiver of Elimination Period for Home Care and Adult Day Care*	Survivorship Benefit	Shared Care Benefit	Limited Pay Period—10 Pay
Annual Increase Benefit	—	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Flexible Increase Benefit	No	—	Yes	Yes	Yes	Yes	No	Yes	No
Nonforfeiture Benefit	Yes	Yes	—	Yes	Yes	Yes	Yes	Yes	Yes
Return of Premium Upon Death	Yes	Yes	Yes	—	Yes	Yes	Yes	No	Yes
Cash Benefit	Yes	Yes	Yes	Yes	—	Yes	Yes	Yes	Yes
Waiver of Elimination Period for Home Care and Adult Day Care*	Yes	Yes	Yes	Yes	Yes	—	Yes	Yes	Yes
Survivorship Benefit	Yes	No	Yes	Yes	Yes	Yes	—	Yes	No
Shared Care Benefit	Yes	Yes	Yes	No	Yes	Yes	Yes	—	Yes
Limited Pay Period—10 Pay	Yes	No	Yes	Yes	Yes	Yes	No	Yes	—

*The Waiver of Elimination Period for Home Care and Adult Day Care is not available with the 180-day elimination period.
CA Rider: Waiver of Elimination Period for Home and Community-Based Care.

Note: The Flexible Increase Benefit is available with the Shared Care Benefit. However, both contract owners must accept or decline their offers at the same time. The coverage must be identical, otherwise, the Shared Care Benefit rider will terminate.

Qualifying for Benefits

Eligibility for the Payment of Benefits

To be eligible for benefits under the long-term care insurance contract, all of the following conditions must be met:

1. Insured is chronically ill and receives qualified long-term care services;
2. For benefits subject to the elimination period, the services are received after that period has ended; and
3. Coverage is not listed under the exclusions (see page 32 for exclusions list).

What does it mean to be chronically ill?

On any given day, an insured is chronically ill if a licensed health care practitioner has, within the 12-month period preceding that day, certified in writing that he or she has:

1. A physical impairment that is expected to last at least 90 days, or
2. A cognitive impairment.

A physical impairment is an impairment that prevents a person from performing two or more activities of daily living without the substantial assistance of another person.

Substantial assistance means hands-on assistance or standby assistance.

Activities of daily living include:

1. Bathing. Washing oneself in a tub or shower, including getting in or out of the tub or shower, or by sponge bath.
2. Continence. Maintaining control of bowel and bladder functions or, if unable to do so, taking care of the personal hygiene associated with incontinence, including caring for a catheter or colostomy bag.
3. Dressing. Putting on and taking off all items of clothing and any necessary braces, fasteners or prostheses.
4. Eating. Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or, if necessary, by feeding tube or intravenously. Eating does not include preparing meals.
5. Transferring. Moving into or out of a bed, chair or wheelchair.
6. Using the Toilet. Getting to and from the toilet, transferring on and off the toilet and performing the associated personal hygiene.

A cognitive impairment is an impairment of the mind that:

1. Is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia;
2. Is measured by clinical evidence and standardized tests; and
3. Results in the need for continual supervision.

Qualifying for Benefits Continued

What are Qualified Long-Term Care Services?

Qualified long-term care services are:

- Required because the insured is chronically ill; and
- Provided pursuant to a plan of care.

What is a plan of care? Why is it required?

A plan of care is a written document that:

1. Is prepared and signed by a licensed health care practitioner in accordance with accepted standards of practice;
2. Prescribes qualified long-term care services that are consistent with an assessment of the insured's impairment; and
3. Includes services or treatment that could not be omitted without adversely affecting the insured's health.

Thrivent retains the right to discuss the plan of care with the licensed health care practitioner who prepared it. Thrivent may also verify that the plan of care is appropriate and consistent with generally accepted standards of care for a person who is chronically ill. The plan of care must be updated as the insured's needs change. Thrivent must receive a copy of the plan of care upon its completion and each time it is updated. Thrivent retains the right to request periodic updates not more often than once every 30 days. Thrivent will make a copy of the current plan of care available to the insured's doctor, when requested. The insured may only have one plan of care in effect at any time.

Is there a benefit or service available to help the insured with this process?

Yes. Care Coordination Services are available to the insured if he or she would like assistance.

The Care Coordination Benefit, if the insured chooses to use it, pays for a care coordinator to help the insured and his or her family:

- Perform a comprehensive care needs assessment.
- Identify the services needed.
- Locate local caregivers and facilities.
- Assist in developing, implementing and coordinating the insured's plan of care.
- Monitor the insured's ongoing care.

There is no cost to the insured for the services provided by a care coordinator referred by Thrivent. In addition, these services are not subject to the elimination period.

Payment of Benefits

Payment of Benefits/Claims Process

This is a brief outline of the claims process:

1. Contact Thrivent's Claims department.
 - A notice of claim must be submitted to Thrivent at our Service Center within 30 days after a covered loss starts or as soon after this as reasonably possible.
 - An acknowledgement letter will be sent to the insured and the financial professional upon receipt of the request for benefits.
 - A claims representative will review the health status, physician's assessment of care needs, the contract and its available benefits and services, and the credentials of the health care provider or facility providing the care.
 - When all the information has been received and reviewed, a letter explaining the claim decision and next steps will be sent to the insured.
 - If a decision cannot be made, a letter explaining the reason for the delay will be sent to the insured.
2. Contact care coordinator services.
3. Ongoing claim review.
4. Reimbursement for services.

Benefits will be paid to the insured or to the health care provider to whom the insured has assigned benefits. Any benefits payable to the insured that are unpaid at his or her time of death will be paid to his or her estate.

The insured is eligible for reimbursement up to the maximum monthly benefit, subject to the available benefit.

The insured can receive payment for multiple benefit services in one day.

Coordination With Other Coverage

If an expense covered under this contract is also covered by other contracts or a rider issued by Thrivent (or a predecessor organization), the amount payable for that expense under this contract will be reduced by the sum of the amounts that are paid for that expense under the other coverage.

Coordination of benefits will be determined on multiple contracts based on the issue date, beginning with the earliest issued contract paying benefits first.

Coordination of benefits provision applies to: Arizona, California, District of Columbia, Delaware, Hawaii, Indiana, Montana and South Dakota.

Medicare Non-Duplication

Medicare non-duplication applies. This means that the long-term care contract will not pay benefits for expenses which are reimbursable under Medicare or would be reimbursable under Medicare but for the application of a deductible or coinsurance amount.

Other Important Information	
Right to Cancel	The insured is provided a 30-day period upon receipt of the contract to review and/or rescind the contract. If the insured cancels during this initial 30 days, all premiums paid will be refunded.
Unintentional Lapse	A feature that allows the insured to name someone to be notified if coverage is about to lapse because the premium has not been paid. This could be a relative, friend or professional such as a lawyer or accountant.
Grace Period	A window of time (60 days) to pay each premium that is in default.
Reinstatement	If the contract terminates at the end of the grace period for nonpayment of premiums, the insured may reinstate the contract: • Within six months after the end of the grace period. • Must pay any premiums that are in default. If the insured is NOT chronically ill on the date the unpaid premium was due, the insured must submit an application for reinstatement. If the insured is chronically ill on the date the unpaid premium was due, the insured is not required to submit an application for reinstatement but must provide proof of chronic illness.
Time Limit on Certain Defenses	A contract may be voided due to misstatements in the application as follows: 1. For the first six months the contract is in force, the contract may be voided if it is shown that a misstatement is material to the decision to issue the contract. 2. For losses incurred after the first six months but before the contract has been in force for two years, the contract may be voided if it is shown that a misstatement is both material to the decision to issue the contract and related to the loss for which benefits are sought. 3. For losses incurred after the contract has been in force for two years, the contract may be voided only if it is shown that the insured knowingly and intentionally misstated relevant facts related to his or her health. This provision applies to any additional coverage that is added from its effective date with regard to statements made in the application for the additional coverage.
Exclusions	The long-term care insurance contract does not pay benefits for charges billed by a doctor or charges for prescription drugs. In addition, the long-term care insurance contract does not cover services: • Outside the U.S., its territories and possessions, except as provided under the International Care Benefit. • Necessary due to an attempt at suicide or an intentionally self-inflicted injury. • Provided for the treatment of alcoholism or drug addiction. • Provided by an immediate family member unless: – He or she is a regular employee of a facility or agency that is providing the treatment, services or care; – The facility or agency receives the payment for the treatment, service or care and he or she receives no compensation other than the normal compensation for employees in his or her job category; and – He or she has no ownership or financial interest in the facility or agency providing the treatment, services or care. • For which benefits are payable under any state or federal Workers' Compensation, Occupational Disease or Employer's Liability Laws. An immediate family member means a spouse or partner and anyone who is related to the insured, spouse or partner by blood, adoption or marriage (including step-relatives) as a parent, grandparent, child, grandchild, brother, sister, aunt, uncle, nephew or niece.

Underwriting

For Thrivent Traditional Long-Term Care Insurance underwriting guidelines, refer to the Underwriting Guidelines on FieldNet Underwriting page, including details on:

- Underwriting Requirements by Age
- Preferred Underwriting Checklist
- Uninsurable Conditions

Suitability

National Association of Insurance Commissioners (NAIC) Suitability:

The sale of a long-term care insurance contract must be determined to be suitable. You must determine whether the purchase is appropriate for the needs of the applicant.

Factors that go into determining suitability:

- The prospective insured must have the ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage.
- The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet those goals or needs.
- The values, benefits and cost of the applicant's existing insurance, if any, when compared to the values, benefits and cost of the recommended purchase or replacement.
- The values, benefits and cost of Thrivent's Long-Term Care Insurance when assessed against the applicant's goals or needs.

What are the guidelines for determining suitability?

- In general, a sale of long-term care insurance is NOT suitable if:
 - The applicant has less than \$20,000 in annual income, or less than \$30,000 in assets to protect (savings and investments), unless premium is being paid by a family member or other outside source.
 - The applicant is eligible or about to become eligible for Medicaid.
 - The applicant's only source of income is Social Security or supplemental security income.
 - The applicant otherwise has limited assets and can't afford to pay the premium over the life of the contract.

In order to ensure that a particular long-term care insurance product is suitable, the following elements must also be taken into consideration:

- Who will pay the premium (applicant, child, etc.).
- Where the premium will come from (income, savings, investments, etc.).
- The applicant's living arrangements (e.g., are family and friends available to assist in care, if needed).
- The actual cost of care in the area where the applicant lives.
- How the individual will fund his or her care costs during the elimination period.
- The applicant's needs and how a particular long-term care insurance product can satisfy those needs.
- Which benefits have been selected, including benefit levels, inflation choices, optional benefits, etc.
- What could happen if the individual experiences a change in financial circumstances.
- Does he or she understand that rates could possibly change in the future.

Administrative Questions

Application Processing for Couples

Couples that apply together will be processed together. Thrivent will hold each applicant's file until there is a final underwriting decision on BOTH files. Then they will be processed and issued together with the same issue date; one issued and the other declined; or both declined.

Advance Premium Payment for Conditional Insurance*

The advance premium payment must be at least one month's premium for conditional insurance.

Other pertinent information:

- By making an advance premium payment with the application, underwriting will not be affected by any change in health status that occurs after the latest of:
 - The date the insured makes the advance premium payment, or
 - The date the insured signs the application, or
 - The date the insured completes all tests or physical exams required by Thrivent, if applicable.
- No coverage is effective until the application is approved and a contract is issued.
- Completing an application or making an advance premium payment does not guarantee that the application will be approved.
- If a contract is issued, the insured must pay all premiums when due to keep his or her contract in force.
- If a contract is not issued, any advance premium payment submitted with the application will be refunded without interest.

Is Premium Required With an Application?

No. Premium is not required with an application.

If at least one month's premium is submitted or EFT is selected with the application, Thrivent will consider health history as of the time of application regardless of any subsequent changes in health.

NOTE: For CA, premium is not allowed with the application.

Preliminary Declaration of Insurability for Long-Term Care Insurance

Complete the Preliminary DOI for Long-Term Care Insurance, form 27253. The state-specific form can be found on the Thrivent Online Forms Utility page (TOFU).

*This is not available for CA.

Long-Term Care Insurance Partnership Information

Some states have long-term care insurance partnership programs designed to encourage people to plan ahead for potential long-term care needs by acquiring long-term care insurance. Under these partnership programs, when a partnership-eligible long-term care insurance contract is purchased, the contract owner will receive protection known as “asset disregard” if he or she needs to apply for Medicaid. Neither the state nor federal government issues contracts; private insurance companies issue long-term care insurance. The government-provided asset disregard programs vary by state. The long-term care partnership program is a creation of federal law allowing states to alter their Medicaid programs to allow assets to be disregarded based upon claims paid by eligible qualified long-term care insurance contracts. Most states allow a dollar-for-dollar asset disregard for claims paid on qualified partnership contracts and will not require an insured to exhaust the benefits offered under the partnership contract in order to qualify for Medicaid.

Benefits of the Partnership Program

- Partnership long-term care insurance contracts are tax-qualified plans under federal law and must contain certain consumer protections and provide inflation protection benefits for purchasers so that benefits keep up with the cost of inflation over time.
- The long-term care partnership program provides an alternative to spending down or transferring assets by forming a partnership between Medicaid and private long-term care insurers.
- Once private insurance benefits are used, special Medicaid eligibility rules are applied if additional long-term care is needed.

Key Features of Long-Term Care Partnership Plans

- The contracts must be tax-qualified plans.
- Contracts must provide the following inflation protection:
 - Insureds under age 61 at date of purchase must have compound annual inflation protection.
 - Insureds at least 61 years of age but under the age of 76 must have some level of inflation protection.
 - Insureds older than age 76 may have, but are not required to have, inflation protection.

How Will an Insured Know if He or She Purchased a Partnership Plan?

- If the contract he or she purchased is a partnership eligible plan, he or she will receive written notice from the insurance company. Depending upon the state, the notice will be provided in one of the following ways:
 - His or her contract or certificate will be identified as a partnership plan in the contract itself—either on the front page or on the schedule page of the contract.
 - He or she will receive a letter from his or her insurance company advising him or her that he or she has purchased a partnership contract. If this is the only notification he or she receives, it is extremely important to keep this letter.

Please keep in mind that these programs have specific requirements in each state in which they are offered. Check with your state insurance department or counseling program to see if these contracts are available in your state. Many states with long-term care partnership programs have information on their websites. To locate your state’s insurance department website, visit www.naic.org/state_web_map.htm. The U.S. Department of Health and Human Services maintains a website with information on long-term care insurance and the partnership program at www.longtermcare.gov.

Long-Term Care Insurance Taxation

Thrivent's Traditional Long-Term Care Insurance is intended to be federally tax-qualified. This means:

- Premiums can be included with other annual uncompensated medical expenses for deductions from income in excess of 7.5% of adjusted gross income up to a maximum amount adjusted for inflation.
- Benefits received and used to pay for long-term care services generally will not be counted as income. For contracts that pay benefits using the expense-incurred method (like Thrivent's contracts), benefits received in excess of the costs of long-term care services may be taxable.
- To trigger the benefits under the contract, federal law requires insureds to be unable to do two activities of daily living without substantial assistance.
- "Medical necessity" cannot be used as a trigger for benefits.
- Chronic illness or disability must be expected to last for at least 90 days.
- For cognitive impairment to be covered, a person must require substantial supervision.

Please advise your clients to consult his or her tax consultant or legal advisor regarding the tax consequences in his or her situation.

Conversions and Replacements

All conversions and replacements must meet suitability guidelines.

For Previously Sold, Existing Contracts:

Prior AAL or LB contracts, Genworth or John Hancock contracts, Thrivent Long-Term Care Insurance or Thrivent Security One Annuity With a Long-Term Care Insurance Rider	No conversion is allowed. If the insured would like new coverage, he or she would need to buy a new contract and be underwritten at his or her attained age.
Prior AAL or LB LTCi contracts, or Thrivent LTCi contracts for California residents	For CA, if a client replaces a LTCi contract that we previously issued, they will receive a credit on their new contract, equal to 5% of the premium on the old contract for each year the contract was in force, up to 50%. If the insured would like new coverage, he or she would need to buy a new contract and be underwritten at his or her attained age.
Disability Insurance Contracts with GIO Purchase Option Earning Power (AAL D-Series)*	These contracts offered a long-term care insurance purchase option: - Only available if the long-term care insurance product is offered in the resident state. - Premiums are based on attained age. - Not subject to underwriting. - Only available at ages 55, 60 and 65—must request within 90 days after the insured's birthday. - Cannot be receiving DI benefits or waiver of premium benefits under the DI contract. - Must have minimum DI benefit of two years to be eligible. - Thrivent will require that \$1,500 per month be purchased as the minimum since this is the minimum monthly benefit allowed on the long-term care insurance contract. State variations apply for states with higher minimum issue limits. - The coverage offered will be comprehensive coverage. - Additional coverage can be purchased with underwriting.
Disability Insurance Contracts with GIO Purchase Option LB 96 Series*	These contracts offered a long-term care insurance purchase option: - Only available if the long-term care insurance product is offered in the resident state. - Premiums are based on attained age. - Not subject to underwriting. - Only available at ages 50, 55, 60 and 65—must request within 90 days after the insured's birthday. - Have not received DI benefits or waiver of premium benefits for any of the six months prior to the insured's birthday. - Must have minimum DI benefit of two years to be eligible. - Maximum benefit of: \$2,100 per month x 24 months = \$50,400 or - Minimum allowed by the state. - Additional coverage can be purchased with underwriting.

*For more information on the Disability Insurance Contracts with GIO Purchase Option for Earning Power (AAL D-Series) and LB 96 Series, please see the Health Insurance page on FieldNet and refer to the Previously Sold Products section.

1035 Exchange Overview

Internal Revenue Code (IRC) Section 1035 is a tax law provision that enables a contract owner to exchange an existing contract without incurring a tax on the transferred value(s) and carries over the cost basis of the terminated contract to the destination contract.

- Assignment and surrender requested as part of a 1035 exchange transaction cannot be reversed once the transfer process is complete.
- There is no right to a return of the exchanged contract(s) as a part of the “Right to Cancel” the new contract. Consequently, any taxable gain incurred from exchanging a contract(s) cannot be reversed once the distribution is processed.
- Thrivent cannot request a 1035 exchange from a foreign company.

For more information on 1035 exchanges, and procedures for requesting an Internal or External 1035 Exchange, please see [FieldNet](#).

Eligible 1035 Exchanges for Long-Term Care Insurance

Transactions eligible for 1035 exchange treatment for long-term care insurance		
From	To	Type of Exchange
Life Insurance	NEW Life Insurance	Full exchange only
	NEW nonqualified annuity	Full exchange only
	NEW qualified long-term care (LTC) insurance	Full exchange only
	EXISTING nonqualified annuity	Full exchange only
	EXISTING qualified LTC Insurance	Full exchange only
Nonqualified Annuity	NEW nonqualified annuity	Partial or full exchange
	NEW qualified LTC Insurance	Partial or full exchange
	EXISTING nonqualified annuity	Full exchange only
	EXISTING qualified LTC Insurance	Partial or full exchange
Qualified LTC Insurance	NEW qualified LTC Insurance	Partial or full exchange
	EXISTING qualified LTC Insurance	Partial or full exchange

Appendix A: Tables for Substantial Premium Rate Increases

A substantial premium increase is an increase that results in a cumulative percentage increase in premiums since the date of issue that equals or exceeds the percentage shown below:

Table 1: Triggering substantial premium rate increase for lifetime premium

Issue Ages	Percent Increase	Issue Ages	Percent Increase	Issue Ages	Percent Increase
29 or under	200%	66	48%	79	22%
30 to 34	190%	67	46%	80	20%
35 to 39	170%	68	44%	81	19%
40 to 44	150%	69	42%	82	18%
45 to 49	130%	70	40%	83	17%
50 to 54	110%	71	38%	84	16%
55 to 59	90%	72	36%	85	15%
60	70%	73	34%	86	14%
61	66%	74	32%	87	13%
62	62%	75	30%	88	12%
63	58%	76	28%	89	11%
64	54%	77	26%	90 or over	10%
65	50%	78	24%		

Table 2: Triggering substantial premium rate increase for limited pay premium

Issue Ages	Percent Increase
Under 65	50%
65-80	30%
Over 80	10%