GREAT SOUTHERN LIFE INSURANCE COMPANY
Outline of Coverage
Medicare Supplement Benefit Plans A, G, and N
(Medicare Eligible 1/1/2020 and after)
Medicare Supplement Benefit Plans A, F, High Deductible Plan F, G, and N
(Medicare Eligible before 1/1/2020)

This chart shows the benefits included in each of the standard Medicare Supplement plans. Only applicants who are **first** eligible for Medicare before 2020 may purchase Plans C, F and High Deductible F. Some plans may not be available in your state.

Note: A √ means 100% of the benefit is paid.

	Plans Available to All Applicants								Medicare first eligible before 2020 only	
Benefits	**A**	**B**	**D**	**G/G[1]**	**K**	**L**	**M**	**N**	**C**	**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 2022					**$6,620[2]**	**$3,310[2]**				

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of $2,490 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 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] Plans 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.

Monthly Rates by Plan – Nevada
Zip Codes: All Zip Codes that start with 889-892
Non-Tobacco Rates

Attained Age	Plan A		HD Plan F*		Plan F*		Plan G		Plan N	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
65	151.26	173.95	44.35	51.00	169.48	194.90	148.10	170.32	102.51	117.89
66	151.26	173.95	44.35	51.00	169.48	194.90	148.10	170.32	102.51	117.89
67	151.26	173.95	44.35	51.00	169.48	194.90	148.10	170.32	102.51	117.89
68	151.26	173.95	44.35	51.00	169.48	194.90	148.10	170.32	102.51	117.89
69	154.18	177.31	45.78	52.65	172.52	198.40	148.10	170.32	104.67	120.37
70	159.94	183.93	48.03	55.24	178.53	205.31	148.10	170.32	108.65	124.95
71	164.72	189.43	49.73	57.19	184.27	211.91	153.39	176.40	112.57	129.45
72	169.50	194.93	51.43	59.14	190.01	218.51	158.67	182.48	116.48	133.96
73	174.81	201.03	53.28	61.28	196.34	225.79	164.45	189.12	120.76	138.88
74	180.14	207.16	55.15	63.42	202.70	233.10	170.27	195.81	125.06	143.82
75	186.99	215.03	57.31	65.91	210.76	242.38	177.52	204.15	130.42	149.99
76	195.16	224.44	60.07	69.08	217.38	249.99	186.75	214.76	137.39	158.00
77	201.85	232.13	62.36	71.72	226.17	260.09	194.63	223.82	143.36	164.87
78	208.94	240.28	64.71	74.42	235.45	270.77	202.95	233.39	149.67	172.13
79	216.45	248.92	67.12	77.19	245.27	282.06	211.75	243.52	156.35	179.80
80	224.19	257.82	69.60	80.04	255.42	293.74	220.85	253.98	163.25	187.74
81	232.89	267.83	72.14	82.96	267.64	307.78	231.75	266.51	171.68	197.43
82	240.04	276.04	74.15	85.28	278.18	319.90	241.21	277.39	179.06	205.92
83	247.14	284.21	76.20	87.63	288.76	332.08	250.73	288.34	186.50	214.47
84	254.44	292.60	78.27	90.01	299.68	344.63	260.54	299.62	194.17	223.30
85	261.93	301.22	80.29	92.33	310.92	357.55	270.65	311.25	202.09	232.40
86	268.54	308.82	82.01	94.31	321.10	369.26	279.76	321.72	209.23	240.61
87	275.32	316.61	83.74	96.30	331.57	381.30	289.13	332.50	216.57	249.06
88	282.26	324.60	85.50	98.33	342.33	393.68	298.77	343.58	224.14	257.76
89	289.37	332.77	87.28	100.37	353.40	406.41	308.69	354.99	231.93	266.72
90	296.65	341.15	89.08	102.44	364.79	419.51	318.89	366.72	239.95	275.94
91	303.18	348.65	90.71	104.32	375.64	431.99	328.57	377.86	247.62	284.77
92	308.63	354.92	92.36	106.22	385.27	443.06	337.20	387.78	254.52	292.70
93	314.18	361.31	94.04	108.14	395.12	454.38	346.03	397.93	261.58	300.81
94	319.83	367.81	95.72	110.08	405.19	465.96	355.06	408.32	268.80	309.12
95	325.58	374.42	97.43	112.05	415.49	477.81	364.29	418.94	276.20	317.63
96	330.46	380.04	98.12	112.83	421.72	484.98	369.76	425.22	280.34	322.39
97	335.42	385.74	98.80	113.62	428.05	492.25	375.30	431.60	284.54	327.23
98	340.45	391.52	99.49	114.42	434.47	499.64	380.93	438.07	288.81	332.13
99	345.56	397.39	100.19	115.22	440.98	507.13	386.65	444.64	293.14	337.12

For Annual Premium mode, multiply monthly rate by 12. For Class 1 rates multiply by 1.15.

Monthly Rates by Plan – Nevada
Zip Codes: All Zip Codes that start with 889-892
Tobacco Rates

Attained Age	Plan A		HD Plan F*		Plan F*		Plan G		Plan N	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
65	173.95	200.04	51.00	58.65	194.90	224.14	170.32	195.86	117.89	135.58
66	173.95	200.04	51.00	58.65	194.90	224.14	170.32	195.86	117.89	135.58
67	173.95	200.04	51.00	58.65	194.90	224.14	170.32	195.86	117.89	135.58
68	173.95	200.04	51.00	58.65	194.90	224.14	170.32	195.86	117.89	135.58
69	177.31	203.90	52.65	60.55	198.40	228.16	170.32	195.86	120.37	138.42
70	183.93	211.51	55.24	63.53	205.31	236.11	170.32	195.86	124.95	143.69
71	189.43	217.84	57.19	65.77	211.91	243.70	176.40	202.85	129.45	148.87
72	194.93	224.17	59.14	68.01	218.51	251.29	182.48	209.85	133.96	154.05
73	201.03	231.18	61.28	70.47	225.79	259.65	189.12	217.49	138.88	159.71
74	207.16	238.24	63.42	72.94	233.10	268.07	195.81	225.18	143.82	165.40
75	215.03	247.29	65.91	75.80	242.38	278.74	204.15	234.77	149.99	172.48
76	224.44	258.11	69.08	79.44	249.99	287.49	214.76	246.98	158.00	181.69
77	232.13	266.95	71.72	82.47	260.09	299.10	223.82	257.39	164.87	189.60
78	240.28	276.32	74.42	85.58	270.77	311.38	233.39	268.40	172.13	197.95
79	248.92	286.25	77.19	88.77	282.06	324.37	243.52	280.04	179.80	206.77
80	257.82	296.49	80.04	92.04	293.74	337.80	253.98	292.08	187.74	215.90
81	267.83	308.00	82.96	95.40	307.78	353.95	266.51	306.49	197.43	227.04
82	276.04	317.45	85.28	98.07	319.90	367.89	277.39	319.00	205.92	236.80
83	284.21	326.85	87.63	100.77	332.08	381.89	288.34	331.59	214.47	246.64
84	292.60	336.49	90.01	103.51	344.63	396.32	299.62	344.56	223.30	256.79
85	301.22	346.40	92.33	106.18	357.55	411.19	311.25	357.94	232.40	267.26
86	308.82	355.15	94.31	108.45	369.26	424.65	321.72	369.98	240.61	276.70
87	316.61	364.11	96.30	110.75	381.30	438.49	332.50	382.37	249.06	286.42
88	324.60	373.28	98.33	113.07	393.68	452.73	343.58	395.12	257.76	296.43
89	332.77	382.69	100.37	115.42	406.41	467.38	354.99	408.24	266.72	306.73
90	341.15	392.32	102.44	117.80	419.51	482.44	366.72	421.73	275.94	317.33
91	348.65	400.95	104.32	119.96	431.99	496.78	377.86	434.54	284.77	327.48
92	354.92	408.16	106.22	122.15	443.06	509.52	387.78	445.95	292.70	336.60
93	361.31	415.50	108.14	124.36	454.38	522.54	397.93	457.62	300.81	345.94
94	367.81	422.98	110.08	126.60	465.96	535.86	408.32	469.56	309.12	355.49
95	374.42	430.58	112.05	128.86	477.81	549.48	418.94	481.78	317.63	365.27
96	380.04	437.04	112.83	129.76	484.98	557.72	425.22	489.00	322.39	370.75
97	385.74	443.60	113.62	130.67	492.25	566.09	431.60	496.34	327.23	376.31
98	391.52	450.25	114.42	131.58	499.64	574.58	438.07	503.78	332.13	381.95
99	397.39	457.00	115.22	132.50	507.13	583.20	444.64	511.34	337.12	387.68

For Annual Premium mode, multiply monthly rate by 12. For Class 1 rates multiply by 1.15.

Monthly Rates by Plan – Nevada
Zip Codes: All Zip Codes that start with 893-898
Non-Tobacco Rates

Attained Age	Plan A		HD Plan F*		Plan F*		Plan G		Plan N	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
65	137.25	157.84	40.24	46.28	153.79	176.86	134.39	154.55	93.02	106.98
66	137.25	157.84	40.24	46.28	153.79	176.86	134.39	154.55	93.02	106.98
67	137.25	157.84	40.24	46.28	153.79	176.86	134.39	154.55	93.02	106.98
68	137.25	157.84	40.24	46.28	153.79	176.86	134.39	154.55	93.02	106.98
69	139.91	160.89	41.54	47.77	156.55	180.03	134.39	154.55	94.98	109.22
70	145.13	166.90	43.59	50.12	162.00	186.30	134.39	154.55	98.59	113.38
71	149.47	171.89	45.13	51.90	167.21	192.29	139.18	160.06	102.14	117.47
72	153.81	176.88	46.67	53.67	172.42	198.28	143.98	165.58	105.70	121.55
73	158.62	182.41	48.35	55.60	178.16	204.88	149.23	171.61	109.58	126.02
74	163.46	187.98	50.05	57.55	183.93	211.52	154.50	177.68	113.48	130.51
75	169.67	195.12	52.01	59.81	191.25	219.94	161.08	185.24	118.35	136.10
76	177.09	203.66	54.51	62.68	197.25	226.84	169.46	194.88	124.67	143.37
77	183.16	210.63	56.59	65.08	205.22	236.01	176.61	203.10	130.09	149.60
78	189.59	218.03	58.72	67.53	213.65	245.70	184.16	211.78	135.82	156.19
79	196.41	225.87	60.91	70.05	222.56	255.95	192.15	220.97	141.87	163.15
80	203.43	233.95	63.15	72.62	231.77	266.54	200.40	230.47	148.13	170.36
81	211.33	243.03	65.46	75.28	242.86	279.28	210.29	241.83	155.78	179.15
82	217.81	250.48	67.29	77.38	252.42	290.28	218.87	251.70	162.48	186.85
83	224.26	257.90	69.14	79.51	262.03	301.33	227.51	261.64	169.23	194.61
84	230.88	265.51	71.02	81.68	271.93	312.72	236.41	271.88	176.19	202.62
85	237.68	273.33	72.86	83.78	282.13	324.45	245.59	282.43	183.38	210.88
86	243.68	280.23	74.41	85.58	291.36	335.07	253.86	291.93	189.85	218.33
87	249.82	287.30	75.99	87.39	300.87	345.99	262.36	301.71	196.52	226.00
88	256.12	294.54	77.58	89.22	310.63	357.23	271.10	311.77	203.39	233.90
89	262.57	301.96	79.20	91.08	320.68	368.78	280.10	322.12	210.45	242.02
90	269.18	309.56	80.83	92.95	331.02	380.67	289.36	332.76	217.73	250.39
91	275.10	316.37	82.31	94.66	340.86	391.99	298.15	342.87	224.70	258.40
92	280.05	322.06	83.81	96.38	349.60	402.03	305.98	351.88	230.95	265.60
93	285.09	327.85	85.33	98.13	358.53	412.31	313.99	361.09	237.36	272.96
94	290.22	333.75	86.86	99.89	367.67	422.82	322.18	370.51	243.91	280.50
95	295.44	339.75	88.41	101.67	377.02	433.57	330.56	380.15	250.62	288.22
96	299.87	344.85	89.03	102.39	382.67	440.07	335.52	385.85	254.38	292.54
97	304.36	350.02	89.65	103.10	388.41	446.67	340.55	391.64	258.20	296.93
98	308.93	355.27	90.28	103.82	394.24	453.37	345.66	397.51	262.07	301.38
99	313.56	360.60	90.91	104.55	400.15	460.17	350.85	403.47	266.00	305.90

For Annual Premium mode, multiply monthly rate by 12. For Class 1 rates multiply by 1.15.

Monthly Rates by Plan – Nevada
Zip Codes: All Zip Codes that start with 893-898
Tobacco Rates

Attained Age	Plan A		HD Plan F*		Plan F*		Plan G		Plan N	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
65	157.84	181.52	46.28	53.22	176.86	203.39	154.55	177.73	106.98	123.02
66	157.84	181.52	46.28	53.22	176.86	203.39	154.55	177.73	106.98	123.02
67	157.84	181.52	46.28	53.22	176.86	203.39	154.55	177.73	106.98	123.02
68	157.84	181.52	46.28	53.22	176.86	203.39	154.55	177.73	106.98	123.02
69	160.89	185.02	47.77	54.94	180.03	207.03	154.55	177.73	109.22	125.61
70	166.90	191.93	50.12	57.64	186.30	214.24	154.55	177.73	113.38	130.39
71	171.89	197.67	51.90	59.68	192.29	221.13	160.06	184.07	117.47	135.09
72	176.88	203.41	53.67	61.72	198.28	228.02	165.58	190.42	121.55	139.79
73	182.41	209.78	55.60	63.94	204.88	235.61	171.61	197.35	126.02	144.92
74	187.98	216.18	57.55	66.18	211.52	243.25	177.68	204.33	130.51	150.08
75	195.12	224.39	59.81	68.78	219.94	252.93	185.24	213.03	136.10	156.51
76	203.66	234.21	62.68	72.08	226.84	260.87	194.88	224.11	143.37	164.87
77	210.63	242.23	65.08	74.84	236.01	271.41	203.10	233.56	149.60	172.04
78	218.03	250.73	67.53	77.66	245.70	282.55	211.78	243.55	156.19	179.62
79	225.87	259.75	70.05	80.55	255.95	294.34	220.97	254.11	163.15	187.63
80	233.95	269.04	72.62	83.52	266.54	306.52	230.47	265.03	170.36	195.91
81	243.03	279.48	75.28	86.57	279.28	321.18	241.83	278.11	179.15	206.02
82	250.48	288.06	77.38	88.99	290.28	333.82	251.70	289.46	186.85	214.88
83	257.90	296.58	79.51	91.44	301.33	346.53	261.64	300.88	194.61	223.81
84	265.51	305.34	81.68	93.93	312.72	359.62	271.88	312.66	202.62	233.02
85	273.33	314.33	83.78	96.35	324.45	373.12	282.43	324.80	210.88	242.51
86	280.23	322.26	85.58	98.41	335.07	385.33	291.93	335.72	218.33	251.08
87	287.30	330.39	87.39	100.50	345.99	397.89	301.71	346.97	226.00	259.90
88	294.54	338.72	89.22	102.60	357.23	410.81	311.77	358.54	233.90	268.98
89	301.96	347.25	91.08	104.74	368.78	424.10	322.12	370.44	242.02	278.33
90	309.56	356.00	92.95	106.89	380.67	437.77	332.76	382.68	250.39	287.95
91	316.37	363.83	94.66	108.86	391.99	450.78	342.87	394.31	258.40	297.16
92	322.06	370.37	96.38	110.84	402.03	462.34	351.88	404.66	265.60	305.44
93	327.85	377.03	98.13	112.84	412.31	474.16	361.09	415.25	272.96	313.91
94	333.75	383.81	99.89	114.87	422.82	486.24	370.51	426.09	280.50	322.57
95	339.75	390.71	101.67	116.93	433.57	498.60	380.15	437.17	288.22	331.45
96	344.85	396.57	102.39	117.74	440.07	506.08	385.85	443.73	292.54	336.42
97	350.02	402.52	103.10	118.57	446.67	513.67	391.64	450.38	296.93	341.47
98	355.27	408.56	103.82	119.40	453.37	521.38	397.51	457.14	301.38	346.59
99	360.60	414.69	104.55	120.23	460.17	529.20	403.47	463.99	305.90	351.79

For Annual Premium mode, multiply monthly rate by 12. For Class 1 rates multiply by 1.15

GREAT SOUTHERN LIFE INSURANCE COMPANY
Outline of Coverage
Medicare Supplement Benefit Plans A, G, and N
(Medicare Eligible 1/1/2020 and after)
Medicare Supplement Benefit Plans A, F, High Deductible Plan F, G, and N
(Medicare Eligible before 1/1/2020)

Disclosures. Use this outline to compare benefits and premiums among policies.

Premium Information. Great Southern Life Insurance Company can only raise your premium if we raise the premium for all policies like yours in the same geographic area of the state where you live. Until you are age 99, your premium may change each year. This change will only be made on the first renewal date that coincides with or follows each anniversary of the effective date. Schedules of rates may vary depending upon your effective date.

One time Policy Fee: $25.00

Household Premium Discount. If you resided with at least one, but no more than three, other adults who are age 60 or older for the past year, you will be eligible for a household premium discount. The discounted premium will be priced 14% lower than the rates illustrated. **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 us.**

Right to Return Policy. If you find that you are not satisfied with your policy, you may return it to us at our Medicare Supplement Administrative Offices: PO Box 10812, Clearwater, FL 33757-8812. 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. The policy may not fully cover all of your medical costs. Neither we nor our agents are connected with Medicare. This outline does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare & 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. We may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. **Review the application carefully before you sign it. Be certain that all information has been properly recorded.**

No Health Review. No health review is required if you enroll within the first six months after you reach age 65 and enroll in Medicare Part B, or in other situations as required by law.

PLEASE REFER TO YOUR POLICY FOR DETAILS.

GREAT SOUTHERN LIFE INSURANCE COMPANY
Outline of Coverage

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 A Pays	You Pay
Hospitalization Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,556	$0	$1,556 Part A Deductible
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $778 a day	$778 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 thru 100th days	All but $194.50 a day	$0	Up to $194.50 a day
101st day and after	$0	$0	All Costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

NOTICE: **When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan A

Medicare Part B – Medical Services per Calendar Year. *Once you have been billed $233 of Medicare Eligible Expenses for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan A 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 $233 of Medicare approved amounts*	$0	$0	$233 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 $233 of Medicare approved amounts*	$0	$0	$233 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 A Pays	You Pay
Home Health Care Medicare Eligible Services			
▪ Medically necessary skilled care services and medical supplies	100%	$0	$0
▪ Durable medical equipment. First $233 of Medicare approved amounts*	$0	$0	$233 Part B Deductible
▪ Remainder of Medicare approved amounts	80%	20%	$0

GREAT SOUTHERN LIFE INSURANCE COMPANY
Outline of Coverage

Plan F or High Deductible Plan F *(only available if Medicare Eligible prior to 01/01/2020)*

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 F Pays (After You pay $2,490 Deductible**)	You Pay (In addition to $2,490 Deductible**)
Hospitalization			
Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,556	$1,556 Part A Deductible	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $778 a day	$778 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 thru 100th days	All but $194.50 a day	Up to $194.50 a day	$0
101st day and after	$0	$0	All Costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

Services	Medicare Pays	Plan F Pays (**After You pay $2,490 Deductible**)	You Pay (**In addition to $2,490 Deductible**)
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**The High Deductible Plan F pays the same benefits as Plan F after you have paid a calendar year $2,490 deductible. Benefits from the High Deductible Plan F will not begin until out-of-pocket expenses are $2,490. Out-of-pocket expenses for this deductible include expense for the Medicare Part B deductible and expense that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

Medicare Part B – Medical Services per Calendar Year

*Once you have been billed $233 of Medicare Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan F Pays (After You pay $2,490 Deductible**)	You Pay (In addition to $2,490 Deductible**)
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 $233 of Medicare approved amounts*	$0	$233 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 $233 of Medicare approved amounts*	$0	$233 Part B Deductible	$0
Remainder of Medicare approved amounts	80%	20%	$0
Clinical Laboratory Services – Tests for Diagnostic services	100%	$0	$0

Plan F or High Deductible Plan F *(only available if Medicare Eligible prior to 01/01/2020)*

Parts A & B

Services	Medicare Pays	Plan F Pays (After You pay $2,490 Deductible**)	You Pay (In addition to $2,490 Deductible**)
Home Health Care Medicare Eligible Services			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment. First $233 of Medicare approved amounts*	$0	$233 Part B Deductible	$0
- Remainder of Medicare approved amounts	80%	20%	$0

**The High Deductible Plan F pays the same benefits as Plan F after you have paid a calendar year $2,490 deductible. Benefits from the High Deductible Plan F will not begin until out-of-pocket expenses are $2,490. Out-of-pocket expenses for this deductible include expense for the Medicare Part B deductible and expense that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

Other Benefits Not Covered by Medicare

Services	Medicare Pays	Plan F Pays (After You pay $2,490 Deductible**)	You Pay (In addition to $2,490 Deductible**)
Foreign Travel 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.

**The High Deductible Plan F pays the same benefits as Plan F after you have paid a calendar year $2,490 deductible. Benefits from the High Deductible Plan F will not begin until out-of-pocket expenses are $2,490. Out-of-pocket expenses for this deductible include expense for the Medicare Part B deductible and expense that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

GREAT SOUTHERN LIFE INSURANCE COMPANY
Outline of Coverage

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 G Pays	You Pay
Hospitalization Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,556	$1,556 Part A Deductible	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $778 a day	$778 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 thru 100 days	All but $194.50 a day	Up to $194.50 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

**When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan G

Medicare Part B – Medical Services per Calendar Year
Once you have been billed $233 of Medicare approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan G 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 $233 of Medicare approved amounts* Remainder of Medicare approved amounts	$0 Generally 80%	$0 Generally 20%	$233 Part B Deductible $0
Part B Excess Charges (above Medicare approved amounts)	$0	100%	$0
Blood First 3 pints Next $233 of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 $233 Part B Deductible $0
Clinical Laboratory Services – Tests for Diagnostic services	100%	$0	$0

Parts A & B

Services	Medicare Pays	Plan G Pays	You Pay
Home Health Care Medicare Eligible Services - Medically necessary skilled care services and medical supplies - Durable medical equipment. First $233 of Medicare approved amounts* - Remainder of Medicare approved amounts	 100% $0 80%	 $0 $0 20%	 $0 $233 Part B Deductible $0

Other Benefits Not Covered by Medicare

Services	Medicare Pays	Plan G Pays	You Pay
Foreign Travel Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA. First $250 each calendar year Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.

GREAT SOUTHERN LIFE INSURANCE COMPANY
Outline of Coverage

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 N Pays	You Pay
Hospitalization Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,556	$1,556 Part A Deductible	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $778 a day	$778 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 thru 100 days	All but $194.50 a day	Up to $194.50 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

**When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan N

Medicare Part B – Medical Services per Calendar Year
*Once you have been billed $233 of Medicare Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan N 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 $233 of Medicare approved amounts*	$0	$0	$233 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 $233 of Medicare approved amounts*	$0	$0	$233 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 N Pays	You Pay
Home Health Care			
Medicare Eligible Services			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment. First $233 of Medicare approved amounts	$0	$0	$233 Part B Deductible
- Remainder of Medicare approved amounts	80%	20%	$0

Plan N

Other Benefits Not Covered by Medicare

Services	Medicare Pays	Plan N Pays	You Pay
Foreign Travel Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA. First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.