

Bankers Conesco Life Insurance Company
Chicago, Illinois

State of New York Rate Manual

1. **Form Caption:** Medicare Supplement
2. **Form Numbers:** BLNY-GR-A06B, BLNY-GR-A06D, BLNY-GR-A06F, BLNY-GR-A06FH, BLNY-GR-A06G, BLNY-GR-A06J, BLNY-GR-A06K, BLNY-GR-A06L, BLNY-GR-A80A, BLNY-GR-A80A(14), BLNY-GR-A80B, BLNY-GR-A80B(14), BLNY-GR-A80F, BLNY-GR-A80F(14), BLNY-GR-A80FH, BLNY-GR-A80FH(14), BLNY-GR-A80G, BLNY-GR-A80G(14), BLNY-GR-A80K, BLNY-GR-A80K(14), BLNY-GR-A80L, BLNY-GR-A80L(14), BLNY-GR-A80M, BLNY-GR-A80M(14), BLNY-GR-A80N, BLNY-GR-A80N(14)
3. **Forms Approved:** BLNY-GR-A06 series plans were approved on July 17, 2006. BLNY-GR-A80 series plans were approved April 12, 2010.
4. **Benefits:** See the following pages for the benefit descriptions by plan.

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Plan B (BLNY-GR-A06B) – for policies with issue dates through May 31, 2010

- A. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for the 61st through the 90th day in any Medicare benefit period.
- B. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day (91st – 150th day of confinement) used.
- C. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the costs incurred for hospitalization expenses covered by Medicare and recognized as medically necessary by Medicare, subject to a lifetime maximum benefit of an additional 365 days.
- D. Coverage under Medicare Part A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) per calendar year.
- E. For Part B approved medical services and supplies, the coinsurance percentage on Medicare eligible expenses after the calendar year deductible.
- F. Medicare Part A Deductible: coverage for the entire Medicare Part A inpatient hospital deductible amount per benefit period.

Plan D (BLNY-GR-A06D) – for policies with issue dates through May 31, 2010

- A. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for the 61st through the 90th day in any Medicare benefit period.
- B. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day (91st – 150th day of confinement) used.
- C. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the costs incurred for hospitalization expenses covered by Medicare and recognized as medically necessary by Medicare, subject to a lifetime maximum benefit of an additional 365 days.
- D. Coverage under Medicare Part A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) per calendar year.
- E. For Part B approved medical services and supplies, the coinsurance percentage on Medicare eligible expenses after the calendar year deductible.
- F. Medicare Part A Deductible: coverage for the entire Medicare Part A inpatient hospital deductible amount per benefit period.
- G. Skilled Nursing Facility Care: coverage for the actual billed charges up to coinsurance amount from the 21st day through the 100th day in a Medicare Part A approved benefit period.
- H. Foreign Travel Emergency: coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States, subject to a calendar year deductible of \$250 and a lifetime maximum benefit of \$50,000. For purposes of this benefit, “emergency care” shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

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- I. At-home Recovery: coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

For purposes of this benefit, the following definitions apply:

- a. Activities of Daily Living – The term includes bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.
- b. Care Provider – A qualified or licensed home health aide or homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses' registry.
- c. Home – A place used by the insured as a place of residence, if the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility may not be considered the insured's place of residence.
- d. At-home Recovery Site – The period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except that each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.

Coverage requirements and limitation are as follows:

- a. At-home recovery services provided shall be primarily services which assist in activities of daily living.
- b. The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

Coverage is limited to:

- a. No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits may not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.
- b. The actual charges for each visit up to a maximum reimbursement of \$40 per visit.
- c. \$1,600 per calendar year.
- d. Seven visits per week.
- e. Care furnished on a visiting basis in the insured's home.
- f. Services provided by a care provider as defined in this section.
- g. At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.
- h. At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight weeks after the service date of the last Medicare approved home health care visit.

Coverage is excluded for:

- a. Home care visits paid for by Medicare or other government programs.
- b. Care provided by family members, unpaid volunteers, or providers who are not care providers.

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Plan F (BLNY-GR-A06F) – for policies with issue dates through May 31, 2010

- A. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for the 61st through the 90th day in any Medicare benefit period.
- B. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day (91st – 150th day of confinement) used.
- C. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the costs incurred for hospitalization expenses covered by Medicare and recognized as medically necessary by Medicare, subject to a lifetime maximum benefit of an additional 365 days.
- D. Coverage under Medicare Part A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) per calendar year.
- E. For Part B approved medical services and supplies, the coinsurance percentage on Medicare eligible expenses after the calendar year deductible.
- F. Medicare Part A Deductible: coverage for the entire Medicare Part A inpatient hospital deductible amount per benefit period.
- G. Skilled Nursing Facility Care: coverage for the actual billed charges up to coinsurance amount from the 21st day through the 100th day in a Medicare Part A approved benefit period.
- H. Medicare Part B Deductible: coverage for the entire Medicare Part B deductible per calendar year regardless of hospital confinement.
- I. Foreign Travel Emergency: coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States, subject to a calendar year deductible of \$250 and a lifetime maximum benefit of \$50,000. For purposes of this benefit, “emergency care” shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.
- J. 100% of Medicare Part B Excess Charges: coverage for the entire difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.

High Deductible Plan F (BLNY-GR-A06FH) – for policies with issue dates through May 31, 2010

- A. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for the 61st through the 90th day in any Medicare benefit period.
- B. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day (91st – 150th day of confinement) used.
- C. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the costs incurred for hospitalization expenses covered by Medicare and recognized as medically necessary by Medicare, subject to a lifetime maximum benefit of an additional 365 days.
- D. Coverage under Medicare Part A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) per calendar year.

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- E. For Part B approved medical services and supplies, the coinsurance percentage on Medicare eligible expenses after the calendar year deductible.
- F. Medicare Part A Deductible: coverage for the entire Medicare Part A inpatient hospital deductible amount per benefit period.
- G. Skilled Nursing Facility Care: coverage for the actual billed charges up to coinsurance amount from the 21st day through the 100th day in a Medicare Part A approved benefit period.
- H. Medicare Part B Deductible: coverage for the entire Medicare Part B deductible per calendar year regardless of hospital confinement.
- I. Foreign Travel Emergency: coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States, subject to a calendar year deductible of \$250 and a lifetime maximum benefit of \$50,000. For purposes of this benefit, “emergency care” shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.
- J. 100% of Medicare Part B Excess Charges: coverage for the entire difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.

This plan covers the expenses as described above, after application of an annual out-of-pocket deductible. This deductible consists of out-of-pocket payments for the services covered above and is in addition to any other specific benefit deductibles. This deductible increases each year as specified by the Secretary of Health and Human Services, according to the CPI increase for all urban consumers.

Plan G (BLNY-GR-A06G) – for policies with issue dates through May 31, 2010

- A. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for the 61st through the 90th day in any Medicare benefit period.
- B. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day (91st – 150th day of confinement) used.
- C. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the costs incurred for hospitalization expenses covered by Medicare and recognized as medically necessary by Medicare, subject to a lifetime maximum benefit of an additional 365 days.
- D. Coverage under Medicare Part A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) per calendar year.
- E. For Part B approved medical services and supplies, the coinsurance percentage on Medicare eligible expenses after the calendar year deductible.
- F. Medicare Part A Deductible: coverage for the entire Medicare Part A inpatient hospital deductible amount per benefit period.
- G. Skilled Nursing Facility Care: coverage for the actual billed charges up to coinsurance amount from the 21st day through the 100th day in a Medicare Part A approved benefit period.

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- H. Foreign Travel Emergency: coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States, subject to a calendar year deductible of \$250 and a lifetime maximum benefit of \$50,000. For purposes of this benefit, “emergency care” shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.
- I. At-home Recovery: coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

For purposes of this benefit, the following definitions apply:

- a. Activities of Daily Living – The term includes bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.
- b. Care Provider – A qualified or licensed home health aide or homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses’ registry.
- c. Home – A place used by the insured as a place of residence, if the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility may not be considered the insured’s place of residence.
- d. At-home Recovery Site – The period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except that each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.

Coverage requirements and limitation are as follows:

- a. At-home recovery services provided shall be primarily services which assist in activities of daily living.
- b. The insured’s attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

Coverage is limited to:

- a. No more than the number and type of at-home recovery visits certified as necessary by the insured’s attending physician. The total number of at-home recovery visits may not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.
- b. The actual charges for each visit up to a maximum reimbursement of \$40 per visit.
- c. \$1,600 per calendar year.
- d. Seven visits per week.
- e. Care furnished on a visiting basis in the insured’s home.
- f. Services provided by a care provider as defined in this section.
- g. At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.
- h. At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight weeks after the service date of the last Medicare approved home health care visit.

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Coverage is excluded for:

- a. Home care visits paid for by Medicare or other government programs.
 - b. Care provided by family members, unpaid volunteers, or providers who are not care providers.
- J. 80% of Medicare Part B Excess Charges: coverage for 80% of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.

Plan J (BLNY-GR-A06J) – for policies with issue dates through May 31, 2010

- A. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for the 61st through the 90th day in any Medicare benefit period.
- B. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day (91st – 150th day of confinement) used.
- C. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the costs incurred for hospitalization expenses covered by Medicare and recognized as medically necessary by Medicare, subject to a lifetime maximum benefit of an additional 365 days.
- D. Coverage under Medicare Part A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) per calendar year.
- E. For Part B approved medical services and supplies, the coinsurance percentage on Medicare eligible expenses after the calendar year deductible.
- F. Medicare Part A Deductible: coverage for the entire Medicare Part A inpatient hospital deductible amount per benefit period.
- G. Skilled Nursing Facility Care: coverage for the actual billed charges up to coinsurance amount from the 21st day through the 100th day in a Medicare Part A approved benefit period.
- H. Medicare Part B Deductible: coverage for the entire Medicare Part B deductible per calendar year regardless of hospital confinement.
- I. Foreign Travel Emergency: coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States, subject to a calendar year deductible of \$250 and a lifetime maximum benefit of \$50,000. For purposes of this benefit, “emergency care” shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.
- J. 100% of Medicare Part B Excess Charges: coverage for the entire difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.
- K. At-home Recovery: coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

For purposes of this benefit, the following definitions apply:

- a. Activities of Daily Living – The term includes bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

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- b. Care Provider – A qualified or licensed home health aide or homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses' registry.
- c. Home – A place used by the insured as a place of residence, if the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility may not be considered the insured's place of residence.
- d. At-home Recovery Site – The period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except that each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.

Coverage requirements and limitation are as follows:

- a. At-home recovery services provided shall be primarily services which assist in activities of daily living.
- b. The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

Coverage is limited to:

- a. No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits may not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.
- b. The actual charges for each visit up to a maximum reimbursement of \$40 per visit.
- c. \$1,600 per calendar year.
- d. Seven visits per week.
- e. Care furnished on a visiting basis in the insured's home.
- f. Services provided by a care provider as defined in this section.
- g. At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.
- h. At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight weeks after the service date of the last Medicare approved home health care visit.

Coverage is excluded for:

- c. Home care visits paid for by Medicare or other government programs.
 - d. Care provided by family members, unpaid volunteers, or providers who are not care providers.
- L. Preventive Care: we will pay for the following preventive health services not covered by Medicare:
- a. An annual clinical preventive medical history and physical examination that may include tests, services, and patient education to address preventive health care measures.
 - b. Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

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We will pay for the actual charges up to 100% of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of \$120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

Plan K (BLNY-GR-A06K) – for policies with issue dates through May 31, 2010

- A. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for the 61st through the 90th day in any Medicare benefit period.
- B. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day (91st – 150th day of confinement) used.
- C. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the costs incurred for hospitalization expenses covered by Medicare and recognized as medically necessary by Medicare, subject to a lifetime maximum benefit of an additional 365 days.
- D. Coverage for 50% under Medicare Part A and B of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) per calendar year.
- E. For Part B approved medical services and supplies, coverage for 50% of the coinsurance percentage on Medicare eligible expenses after the calendar year deductible.
- F. Medicare Part A Deductible: coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period.
- G. Skilled Nursing Facility Care: coverage for 50% of the coinsurance amount from the 21st day through the 100th day in a Medicare Part A approved benefit period.
- H. Hospice Care: coverage for 50% of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as described in paragraph J. below.
- I. Coverage of 100% of the cost sharing for Medicare Part B preventive services after the Part B deductible is met.
- J. Coverage of 100% of all cost sharing under Medicare Part A and B for the balance of the calendar year after reaching the out-of-pocket limitation on annual expenditures under Medicare Part A and B indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

Plan L (BLNY-GR-A06L) – for policies with issue dates through May 31, 2010

- A. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for the 61st through the 90th day in any Medicare benefit period.
- B. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day (91st – 150th day of confinement) used.
- C. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the costs incurred for hospitalization expenses covered by Medicare and recognized as medically necessary by Medicare, subject to a lifetime maximum benefit of an additional 365 days.

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- D. Coverage for 75% under Medicare Part A and B of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) per calendar year.
- E. For Part B approved medical services and supplies, coverage for 75% of the coinsurance percentage on Medicare eligible expenses after the calendar year deductible.
- F. Medicare Part A Deductible: coverage for 75% of the Medicare Part A inpatient hospital deductible amount per benefit period.
- G. Skilled Nursing Facility Care: coverage for 75% of the coinsurance amount from the 21st day through the 100th day in a Medicare Part A approved benefit period.
- H. Hospice Care: coverage for 75% of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as described in paragraph J. below.
- I. Coverage of 100% of the cost sharing for Medicare Part B preventive services after the Part B deductible is met.
- J. Coverage of 100% of all cost sharing under Medicare Part A and B for the balance of the calendar year after reaching the out-of-pocket limitation on annual expenditures under Medicare Part A and B indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

These benefits will automatically change from year to year in accordance with corresponding changes in the coverage provided under Medicare.

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Plan A (BLNY-GR-A80A, BLNY-GR-A80A(14)) – for policies with issue dates of June 1, 2010 and after

- A. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for the 61st through the 90th day in any Medicare benefit period.
- B. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day (91st – 150th day of confinement) used.
- C. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the costs incurred for hospitalization expenses covered by Medicare and recognized as medically necessary by Medicare, subject to a lifetime maximum benefit of an additional 365 days.
- D. Coverage under Medicare Part A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) per calendar year.
- E. For Part B approved medical services and supplies, the coinsurance percentage on Medicare eligible expenses after the calendar year deductible.
- F. Hospice Care: coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

Plan B (BLNY-GR-A80B, BLNY-GR-A80B(14)) – for policies with issue dates of June 1, 2010 and after

- A. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for the 61st through the 90th day in any Medicare benefit period.
- B. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day (91st – 150th day of confinement) used.
- C. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the costs incurred for hospitalization expenses covered by Medicare and recognized as medically necessary by Medicare, subject to a lifetime maximum benefit of an additional 365 days.
- D. Coverage under Medicare Part A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) per calendar year.
- E. For Part B approved medical services and supplies, the coinsurance percentage on Medicare eligible expenses after the calendar year deductible.
- F. Hospice Care: coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
- G. Medicare Part A Deductible: coverage for the entire Medicare Part A inpatient hospital deductible amount per benefit period.

Plan F (BLNY-GR-A80F, BLNY-GR-A80F(14)) – for policies with issue dates of June 1, 2010 and after

- A. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for the 61st through the 90th day in any Medicare benefit period.

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- B. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day (91st – 150th day of confinement) used.
- C. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the costs incurred for hospitalization expenses covered by Medicare and recognized as medically necessary by Medicare, subject to a lifetime maximum benefit of an additional 365 days.
- D. Coverage under Medicare Part A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) per calendar year.
- E. For Part B approved medical services and supplies, the coinsurance percentage on Medicare eligible expenses after the calendar year deductible.
- F. Hospice Care: coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
- G. Medicare Part A Deductible: coverage for the entire Medicare Part A inpatient hospital deductible amount per benefit period.
- H. Skilled Nursing Facility Care: coverage for the actual billed charges up to coinsurance amount from the 21st day through the 100th day in a Medicare Part A approved benefit period.
- I. Medicare Part B Deductible: coverage for the entire Medicare Part B deductible per calendar year regardless of hospital confinement.
- J. Foreign Travel Emergency: coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States, subject to a calendar year deductible of \$250 and a lifetime maximum benefit of \$50,000. For purposes of this benefit, “emergency care” shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.
- K. 100% of Medicare Part B Excess Charges: coverage for the entire difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.

High Deductible Plan F (BLNY-GR-A80FH, BLNY-GR-A80FH(14)) – for policies with issue dates of June 1, 2010 and after

- A. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for the 61st through the 90th day in any Medicare benefit period.
- B. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day (91st – 150th day of confinement) used.
- C. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the costs incurred for hospitalization expenses covered by Medicare and recognized as medically necessary by Medicare, subject to a lifetime maximum benefit of an additional 365 days.
- D. Coverage under Medicare Part A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) per calendar year.
- E. For Part B approved medical services and supplies, the coinsurance percentage on Medicare eligible expenses after the calendar year deductible.

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- F. Hospice Care: coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
- G. Medicare Part A Deductible: coverage for the entire Medicare Part A inpatient hospital deductible amount per benefit period.
- H. Skilled Nursing Facility Care: coverage for the actual billed charges up to coinsurance amount from the 21st day through the 100th day in a Medicare Part A approved benefit period.
- I. Medicare Part B Deductible: coverage for the entire Medicare Part B deductible per calendar year regardless of hospital confinement.
- J. Foreign Travel Emergency: coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States, subject to a calendar year deductible of \$250 and a lifetime maximum benefit of \$50,000. For purposes of this benefit, “emergency care” shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.
- K. 100% of Medicare Part B Excess Charges: coverage for the entire difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.

This plan covers the expenses as described above, after application of an annual out-of-pocket deductible. This deductible consists of out-of-pocket payments for the services covered above and is in addition to any other specific benefit deductibles. This deductible increases each year as specified by the Secretary of Health and Human Services, according to the CPI increase for all urban consumers.

Plan G (BLNY-GR-A80G, BLNY-GR-A80G(14)) – for policies with issue dates of June 1, 2010 and after

- A. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for the 61st through the 90th day in any Medicare benefit period.
- B. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day (91st – 150th day of confinement) used.
- C. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the costs incurred for hospitalization expenses covered by Medicare and recognized as medically necessary by Medicare, subject to a lifetime maximum benefit of an additional 365 days.
- D. Coverage under Medicare Part A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) per calendar year.
- E. For Part B approved medical services and supplies, the coinsurance percentage on Medicare eligible expenses after the calendar year deductible.
- F. Hospice Care: coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
- G. Medicare Part A Deductible: coverage for the entire Medicare Part A inpatient hospital deductible amount per benefit period.
- H. Skilled Nursing Facility Care: coverage for the actual billed charges up to coinsurance amount from the 21st day through the 100th day in a Medicare Part A approved benefit period.

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- I. Foreign Travel Emergency: coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States, subject to a calendar year deductible of \$250 and a lifetime maximum benefit of \$50,000. For purposes of this benefit, “emergency care” shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.
- J. 100% of Medicare Part B Excess Charges: coverage for the entire difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.

Plan K (BLNY-GR-A80K, BLNY-GR-A80K(14)) – for policies with issue dates of June 1, 2010 and after

- A. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for the 61st through the 90th day in any Medicare benefit period.
- B. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day (91st – 150th day of confinement) used.
- C. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the costs incurred for hospitalization expenses covered by Medicare and recognized as medically necessary by Medicare, subject to a lifetime maximum benefit of an additional 365 days.
- D. Coverage for 50% under Medicare Part A and B of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) per calendar year.
- E. For Part B approved medical services and supplies, coverage for 50% of the coinsurance percentage on Medicare eligible expenses after the calendar year deductible.
- F. Medicare Part A Deductible: coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period.
- G. Skilled Nursing Facility Care: coverage for 50% of the coinsurance amount from the 21st day through the 100th day in a Medicare Part A approved benefit period.
- H. Hospice Care: coverage for 50% of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as described in paragraph J. below.
- I. Coverage of 100% of the cost sharing for Medicare Part B preventive services after the Part B deductible is met.
- J. Coverage of 100% of all cost sharing under Medicare Part A and B for the balance of the calendar year after reaching the out-of-pocket limitation on annual expenditures under Medicare Part A and B indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

Plan L (BLNY-GR-A80L, BLNY-GR-A80L(14)) – for policies with issue dates of June 1, 2010 and after

- A. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for the 61st through the 90th day in any Medicare benefit period.

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- B. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day (91st – 150th day of confinement) used.
- C. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the costs incurred for hospitalization expenses covered by Medicare and recognized as medically necessary by Medicare, subject to a lifetime maximum benefit of an additional 365 days.
- D. Coverage for 75% under Medicare Part A and B of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) per calendar year.
- E. For Part B approved medical services and supplies, coverage for 75% of the coinsurance percentage on Medicare eligible expenses after the calendar year deductible.
- F. Medicare Part A Deductible: coverage for 75% of the Medicare Part A inpatient hospital deductible amount per benefit period.
- G. Skilled Nursing Facility Care: coverage for 75% of the coinsurance amount from the 21st day through the 100th day in a Medicare Part A approved benefit period.
- H. Hospice Care: coverage for 75% of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as described in paragraph J. below.
- I. Coverage of 100% of the cost sharing for Medicare Part B preventive services after the Part B deductible is met.
- J. Coverage of 100% of all cost sharing under Medicare Part A and B for the balance of the calendar year after reaching the out-of-pocket limitation on annual expenditures under Medicare Part A and B indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

Plan M (BLNY-GR-A80M, BLNY-GR-A80M(14)) – for policies with issue dates of June 1, 2010 and after

- A. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for the 61st through the 90th day in any Medicare benefit period.
- B. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day (91st – 150th day of confinement) used.
- C. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the costs incurred for hospitalization expenses covered by Medicare and recognized as medically necessary by Medicare, subject to a lifetime maximum benefit of an additional 365 days.
- D. Coverage under Medicare Part A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) per calendar year.
- E. For Part B approved medical services and supplies, the coinsurance percentage on Medicare eligible expenses after the calendar year deductible.
- F. Hospice Care: coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
- G. 50% of Medicare Part A Deductible: coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period.

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- H. Skilled Nursing Facility Care: coverage for the actual billed charges up to coinsurance amount from the 21st day through the 100th day in a Medicare Part A approved benefit period.
- I. Foreign Travel Emergency: coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States, subject to a calendar year deductible of \$250 and a lifetime maximum benefit of \$50,000. For purposes of this benefit, “emergency care” shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

Plan N (BLNY-GR-A80N, BLNY-GR-A80N(14)) – for policies with issue dates of June 1, 2010 and after

- A. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for the 61st through the 90th day in any Medicare benefit period.
- B. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day (91st – 150th day of confinement) used.
- C. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the costs incurred for hospitalization expenses covered by Medicare and recognized as medically necessary by Medicare, subject to a lifetime maximum benefit of an additional 365 days.
- D. Coverage under Medicare Part A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) per calendar year.
- E. After the initial Medicare Part B Deductible, all copayment amounts for medical services and supplies of the type paid under Part B of Medicare to the extent that they are approved by Medicare. Benefits are subject to copayments of up to \$20 per office visit and up to \$50 per emergency room visit, with the emergency room copayment waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
- F. Hospice Care: coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
- G. Medicare Part A Deductible: coverage for the entire Medicare Part A inpatient hospital deductible amount per benefit period.
- H. Skilled Nursing Facility Care: coverage for the actual billed charges up to coinsurance amount from the 21st day through the 100th day in a Medicare Part A approved benefit period.
- I. Foreign Travel Emergency: coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States, subject to a calendar year deductible of \$250 and a lifetime maximum benefit of \$50,000. For purposes of this benefit, “emergency care” shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

These benefits will automatically change from year to year in accordance with corresponding changes in the coverage provided under Medicare.

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- 5. Rates:** Rates are community based, zip code rated. The policies are guaranteed issue. Proposed rates for the BLNY-GR-A06 series are shown in Table 1 and proposed rates for the BLNY-GR-A80 series are shown in Table 2. Rates will not increase as an applicant becomes older, but are subject to change on a statewide basis when 1) there are changes in the coverage being provided because of corresponding changes in Medicare coverage or 2) company experience on these forms warrants a change in rates.

Rate changes will be submitted to the Superintendent of Insurance for approval prior to implementation.

The expected loss ratios for these forms are:

BLNY-GR-A06B:	69.7%	BLNY-GR-A80A, BLNY-GR-A80A(14):	68.3%
BLNY-GR-A06D:	69.7%	BLNY-GR-A80B, BLNY-GR-A80B(14):	67.0%
BLNY-GR-A06F:	70.0%	BLNY-GR-A80F, BLNY-GR-A80F(14):	68.3%
BLNY-GR-A06FH:	70.0%	BLNY-GR-A80FH, BLNY-GR-A80FH(14):	68.3%
BLNY-GR-A06G:	69.7%	BLNY-GR-A80G, BLNY-GR-A80G(14):	68.3%
BLNY-GR-A06J:	70.0%	BLNY-GR-A80K, BLNY-GR-A80K(14):	65.9%
BLNY-GR-A06K:	69.0%	BLNY-GR-A80L, BLNY-GR-A80L(14):	66.7%
BLNY-GR-A06L:	69.2%	BLNY-GR-A80M, BLNY-GR-A80M(14):	68.3%
		BLNY-GR-A80N, BLNY-GR-A80N(14):	68.3%

- 6. Marketing:** These forms will be sold by licensed agents in direct, face-to-face contact with prospective applicants. These forms will not be used in any mass-marketing or mail order program.

7. Underwriting Rules:

- A. These forms can be sold as individual plans only.
- B. No medical underwriting will take place.
- C. There are no age limits.
- D. The company reserves the right to deny insurance to any applicant who is not enrolled in Medicare Parts A and B or is currently covered under a state Medicaid program.
- E. The company reserves the right to deny issuance when such issuance would result in the duplication of Medicare supplement coverage or general over-insurance.
- F. The company also reserves the right to deny issuance in cases of replacement when such replacement is not to the advantage of the applicant.

8. Exclusions and Limitations:

Coverage is not provided for:

- A. any loss not approved for payment under Medicare;
- B. any portion of an eligible expense for a covered loss for which benefits are paid, or payable, by Medicare;
- C. any expense incurred, or portion thereof, which the insured is not legally obligated to pay or would not normally be incurred in the absence of insurance coverage.

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9. Renewability: These forms are guaranteed renewable for life.

10. Preexisting Conditions: For policies written prior to November 23, 2014, no preexisting conditions limitations apply to these forms. For policies written on or after November 23, 2014, which will be written on policy forms BLNY-GR-A80A(14) et al., benefits related to preexisting conditions are excluded for the first six months after issue, except when prohibited.

11. Commission Rates:

Policy Years 1-6

BLNY-GR-A06B:	11%	BLNY-GR-A80A, BLNY-GR-A80A(14):	11%
BLNY-GR-A06D:	11%	BLNY-GR-A80B, BLNY-GR-A80B(14):	11%
BLNY-GR-A06F:	11%	BLNY-GR-A80F, BLNY-GR-A80F(14):	
		11% for issues prior to 11/23/2013; 5% after	
BLNY-GR-A06FH:	7%	BLNY-GR-A80FH, BLNY-GR-A80FH(14):	
		7% for issues prior to 11/23/2013; 9% after	
BLNY-GR-A06G:	11%	BLNY-GR-A80G, BLNY-GR-A80G(14):	11%
BLNY-GR-A06J:	11%	BLNY-GR-A80K, BLNY-GR-A80K(14):	9%
BLNY-GR-A06K:	11%	BLNY-GR-A80L, BLNY-GR-A80L(14):	9%
BLNY-GR-A06L:	11%	BLNY-GR-A80M, BLNY-GR-A80M(14):	11%
		BLNY-GR-A80N, BLNY-GR-A80N(14):	9%

Policy Years 7+

BLNY-GR-A06B:	5%	BLNY-GR-A80A, BLNY-GR-A80A(14):	5%
BLNY-GR-A06D:	5%	BLNY-GR-A80B, BLNY-GR-A80B(14):	5%
BLNY-GR-A06F:	5%	BLNY-GR-A80F, BLNY-GR-A80F(14):	5%
BLNY-GR-A06FH:	5%	BLNY-GR-A80FH, BLNY-GR-A80FH(14):	5%
BLNY-GR-A06G:	5%	BLNY-GR-A80G, BLNY-GR-A80G(14):	5%
BLNY-GR-A06J:	5%	BLNY-GR-A80K, BLNY-GR-A80K(14):	5%
BLNY-GR-A06K:	5%	BLNY-GR-A80L, BLNY-GR-A80L(14):	5%
BLNY-GR-A06L:	5%	BLNY-GR-A80M, BLNY-GR-A80M(14):	5%
		BLNY-GR-A80N, BLNY-GR-A80N(14):	5%

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Table 1

Medicare Supplement Annual Premiums*

Form	Area 1	Area 2	Area 3
BLNY-GR-A06B	\$2,746.01	\$3,192.30	\$3,973.17
BLNY-GR-A06D	\$2,835.58	\$3,296.37	\$4,102.77
BLNY-GR-A06F	\$3,906.08	\$4,540.76	\$5,651.52
BLNY-GR-A06FH	\$899.67	\$1,045.85	\$1,301.66
BLNY-GR-A06G	\$3,111.68	\$3,617.21	\$4,501.93
BLNY-GR-A06J	\$3,562.77	\$4,141.71	\$5,154.61
BLNY-GR-A06K	\$1,142.61	\$1,328.06	\$1,652.93
BLNY-GR-A06L	\$2,037.80	\$2,368.89	\$2,948.27
Zip Codes	130-136, 138-149	109, 120- 129, 137	100-108, 110-119

* To determine the Bank Draft (P.P.S.P.) or Payroll Deduction (P.R.D.), Semi-Annual, Quarterly, or Renewal Direct Bill rates multiply the Annual Rates, as given above, by the appropriate factor shown below and add \$1.00:

0.085853 for Monthly Bank Draft/Payroll Deduction
 0.515 for Semi-Annual
 0.2625 for Quarterly
 0.09167 for Renewal Direct Bill

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Table 2

Medicare Supplement Annual Premiums*

Form	Area 1	Area 2	Area 3
BLNY-GR-A80A, BLNY-GR-A80A(14)	\$2,517.14	\$2,894.16	\$3,649.17
BLNY-GR-A80B, BLNY-GR-A80B(14)	\$2,995.18	\$3,443.86	\$4,342.33
BLNY-GR-A80F, BLNY-GR-A80F(14)	\$3,876.62	\$4,450.33	\$5,620.21
BLNY-GR-A80FH, BLNY-GR-A80FH(14)	\$693.92	\$797.88	\$1,005.92
BLNY-GR-A80G, BLNY-GR-A80G(14)	\$3,102.41	\$3,566.81	\$4,497.45
BLNY-GR-A80K, BLNY-GR-A80K(14)	\$869.01	\$999.05	\$1,259.77
BLNY-GR-A80L, BLNY-GR-A80L(14)	\$1,784.17	\$2,051.44	\$2,586.63
BLNY-GR-A80M, BLNY-GR-A80M(14)	\$2,360.16	\$2,713.72	\$3,421.61
BLNY-GR-A80N, BLNY-GR-A80N(14)	\$1,894.24	\$2,177.76	\$2,746.12
Zip Codes	130-136, 138-149	109, 120-129, 137	100-108, 110-119

* To determine the Bank Draft (P.P.S.P.) or Payroll Deduction (P.R.D.), Semi-Annual, Quarterly, or Renewal Direct Bill rates multiply the Annual Rates, as given above, by the appropriate factor shown below and add \$1.00:

0.085853 for Monthly Bank Draft/Payroll Deduction
0.515 for Semi-Annual
0.2625 for Quarterly
0.09167 for Renewal Direct Bill