

CONSECO INSURANCE COMPANY  
*A life and health insurance company*



# Medicare **supplement**

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Conseco Insurance Company  
2006 Medicare supplement  
CIC-1000

*Outline of Coverage • Missouri*  
*(Accompanies Application book)*



**CONSECO INSURANCE COMPANY**

Outline of Medicare Supplement Coverage - Cover Page  
Benefit Plans A, D, F, G

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A". Some plans may not be available in your state.

**BASIC BENEFITS for Plans A - J:**

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or, copayments for hospital outpatient services.

Blood: First three pints of blood each year.

| A*             | B                 | C                                     | D*                                    | E                                       | F*                                    | F*                                    | G*                                    | H                                     | I                                     | J                                     | J*                                      |
|----------------|-------------------|---------------------------------------|---------------------------------------|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---|
| Basic Benefits | Basic Benefits    | Basic Benefits                        | Basic Benefits                        | Basic Benefits                          | Basic Benefits                        | Basic Benefits                        | Basic Benefits                        | Basic Benefits                        | Basic Benefits                        | Basic Benefits                        | Basic Benefits                          |
|                |                   | Skilled Nursing Facility Co-Insurance | Skilled Nursing Facility Co-Insurance | Skilled Nursing Facility Co-Insurance   | Skilled Nursing Facility Co-Insurance | Skilled Nursing Facility Co-Insurance | Skilled Nursing Facility Co-Insurance | Skilled Nursing Facility Co-Insurance | Skilled Nursing Facility Co-Insurance | Skilled Nursing Facility Co-Insurance | Skilled Nursing Facility Co-Insurance   |
|                | Part A Deductible | Part A Deductible                     | Part A Deductible                     | Part A Deductible                       | Part A Deductible                     | Part A Deductible                     | Part A Deductible                     | Part A Deductible                     | Part A Deductible                     | Part A Deductible                     | Part A Deductible                       |
|                |                   | Part B Deductible                     |                                       |   | Part B Deductible                     |                                       |                                       |                                       |                                       | Part B Deductible                     | Part B Deductible                       |
|                |                   |                                       |                                       |   | Part B Excess (100%)                  |                                       | Part B Excess (80%)                   |                                       | Part B Excess (100%)                  | Part B Excess (100%)                  | Part B Excess (100%)                    |
|                |                   | Foreign Travel Emergency              | Foreign Travel Emergency              | Foreign Travel Emergency                | Foreign Travel Emergency              | Foreign Travel Emergency              | Foreign Travel Emergency              | Foreign Travel Emergency              | Foreign Travel Emergency              | Foreign Travel Emergency              | Foreign Travel Emergency                |
|                |                   |                                       | At-Home Recovery                      |   |                                       |                                       | At-Home Recovery                      |                                       | At-Home Recovery                      | At-Home Recovery                      | At-Home Recovery                        |
|                |                   |                                       |                                       | Preventive Care NOT covered by Medicare |                                       |                                       |                                       |                                       |                                       |                                       | Preventive Care NOT covered by Medicare |

• plans currently available for sale

\* Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year \$1790 deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are \$1790. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare Deductibles for Part A and Part B, but do not include the plan's separate foreign emergency deductible.

Basic Benefits for Plans K and L include similar services as plans A – J, but cost sharing for the basic benefits is at different levels.

| J                                       | K**  | L**   |
|---|--|---|
| Basic Benefits                          | 100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End<br><br>50% Hospice cost-sharing<br><br>50% of Medicare-eligible expenses for the first 3 pints of blood<br><br>50% of Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services | 100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End<br><br>75% Hospice cost-sharing<br><br>75% of Medicare-eligible expenses for the first 3 pints of blood<br><br>75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services |
| Skilled Nursing Facility Coinsurance    | 50% of Skilled Nursing Facility Coinsurance  | 75% of Skilled Nursing Facility Coinsurance   |
| Part A Deductible                       | 50% Part A Deductible  | 75% Part A Deductible   |
| Part B Deductible                       |  |   |
| Part B Excess (100%)                    |  |   |
| Foreign Travel                          |  |   |
| At-Home Recovery                        |  |   |
| Preventive Care NOT Covered by Medicare |  |   |
|   | \$4,000 Out of Pocket Annual Limit***  | \$2,000 Out of Pocket Annual Limit***   |

\*\*Plans K and L provide for different cost-sharing for items and services from Plan A – J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductible for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

\*\*\*The out-of-pocket annual limit will increase each year for inflation.

**Conseco Insurance Company**  
**State of Missouri**  
Form CIC-1000 Issue Age - Preferred Risk  
Gross Premiums -- AREA C  
Zip Codes (634, 637-639, 648, 654-658)

**2006 Annual Rates**

| Female Rates |          |          |          |          | Male Rates |          |          |          |          |
|--------------|----------|----------|----------|----------|------------|----------|----------|----------|----------|
| Issue Age    | Plan A   | Plan D   | Plan F   | Plan G   | Issue Age  | Plan A   | Plan D   | Plan F   | Plan G   |
| Under 65*    | 1,291.50 | 1,519.40 | 1,690.80 | 1,510.90 | Under 65*  | 1,523.80 | 1,743.30 | 1,905.70 | 1,555.10 |
| 65           | 1,064.60 | 1,252.50 | 1,491.90 | 1,277.60 | 65         | 1,204.20 | 1,416.60 | 1,583.50 | 1,445.10 |
| 66           | 1,096.20 | 1,289.70 | 1,513.90 | 1,315.40 | 66         | 1,249.10 | 1,469.60 | 1,626.80 | 1,499.00 |
| 67           | 1,128.80 | 1,328.00 | 1,536.30 | 1,354.60 | 67         | 1,296.00 | 1,524.70 | 1,671.80 | 1,555.10 |
| 68           | 1,162.60 | 1,367.60 | 1,558.10 | 1,395.00 | 68         | 1,344.70 | 1,581.90 | 1,717.10 | 1,613.50 |
| 69           | 1,195.40 | 1,406.40 | 1,581.40 | 1,434.60 | 69         | 1,393.00 | 1,638.90 | 1,764.60 | 1,671.60 |
| 70           | 1,227.60 | 1,444.20 | 1,617.10 | 1,473.00 | 70         | 1,437.60 | 1,691.30 | 1,809.20 | 1,725.10 |
| 71           | 1,259.10 | 1,481.30 | 1,653.90 | 1,510.90 | 71         | 1,481.90 | 1,743.30 | 1,854.90 | 1,778.20 |
| 72           | 1,291.50 | 1,519.40 | 1,690.80 | 1,549.70 | 72         | 1,523.80 | 1,792.70 | 1,905.70 | 1,828.50 |
| 73           | 1,324.20 | 1,557.90 | 1,728.60 | 1,589.00 | 73         | 1,566.30 | 1,842.70 | 1,958.10 | 1,879.60 |
| 74           | 1,349.90 | 1,588.10 | 1,761.30 | 1,619.80 | 74         | 1,604.60 | 1,887.80 | 2,004.90 | 1,925.50 |
| 75           | 1,375.60 | 1,618.30 | 1,794.00 | 1,650.70 | 75         | 1,643.40 | 1,933.40 | 2,052.60 | 1,972.10 |
| 76           | 1,396.70 | 1,643.20 | 1,821.50 | 1,676.10 | 76         | 1,676.90 | 1,972.90 | 2,094.50 | 2,012.40 |
| 77           | 1,418.80 | 1,669.20 | 1,848.20 | 1,702.50 | 77         | 1,707.70 | 2,009.10 | 2,125.90 | 2,049.30 |
| 78           | 1,440.80 | 1,695.10 | 1,875.80 | 1,729.00 | 78         | 1,738.60 | 2,045.50 | 2,157.70 | 2,086.40 |
| 79           | 1,455.20 | 1,711.90 | 1,899.30 | 1,746.10 | 79         | 1,764.70 | 2,076.10 | 2,190.10 | 2,117.70 |
| 80           | 1,469.60 | 1,728.90 | 1,922.80 | 1,763.50 | 80         | 1,791.20 | 2,107.20 | 2,223.00 | 2,149.40 |
| 81           | 1,484.20 | 1,746.10 | 1,941.20 | 1,781.00 | 81         | 1,818.00 | 2,138.90 | 2,256.30 | 2,181.70 |
| 82           | 1,498.90 | 1,763.40 | 1,958.60 | 1,798.60 | 82         | 1,845.40 | 2,170.90 | 2,290.20 | 2,214.40 |
| 83           | 1,513.80 | 1,780.90 | 1,977.00 | 1,816.50 | 83         | 1,873.00 | 2,203.50 | 2,324.60 | 2,247.60 |
| 84           | 1,528.70 | 1,798.50 | 1,994.40 | 1,834.50 | 84         | 1,901.10 | 2,236.60 | 2,359.40 | 2,281.30 |
| 85+          | 1,544.00 | 1,816.40 | 2,011.70 | 1,852.80 | 85+        | 1,929.60 | 2,270.10 | 2,394.80 | 2,315.50 |

Annual Premium Conversion Formulas  
Semi-Annual - Annual x .525, Quarterly - Annual x .2625,  
Monthly PAC - Annual x .085

Add \$15 Policy Fee (non-commissionable, non-refundable) to first premium payment.

\*On Medicare due to disability.

**Conseco Insurance Company**  
**State of Missouri**  
Form CIC-1000 Issue Age - Standard Risk  
Gross Premiums -- AREA C  
Zip Codes (634, 637-639, 648, 654-658)

**2006 Annual Rates**

| Female Rates |          |          |          |          | Male Rates |          |          |          |          |
|--------------|----------|----------|----------|----------|------------|----------|----------|----------|----------|
| Issue Age    | Plan A   | Plan D   | Plan F   | Plan G   | Issue Age  | Plan A   | Plan D   | Plan F   | Plan G   |
| Under 65*    | 1,519.40 | 1,787.50 | 1,989.10 | 1,777.50 | Under 65*  | 1,792.70 | 2,051.00 | 2,182.30 | 1,747.20 |
| 65           | 1,064.60 | 1,252.50 | 1,491.90 | 1,277.60 | 65         | 1,204.20 | 1,416.60 | 1,583.50 | 1,445.10 |
| 66           | 1,165.60 | 1,371.40 | 1,581.80 | 1,398.80 | 66         | 1,330.10 | 1,564.80 | 1,698.30 | 1,596.10 |
| 67           | 1,266.70 | 1,490.20 | 1,671.60 | 1,520.00 | 67         | 1,456.00 | 1,713.00 | 1,813.40 | 1,747.20 |
| 68           | 1,367.60 | 1,609.00 | 1,833.00 | 1,641.20 | 68         | 1,581.90 | 1,861.10 | 2,020.00 | 1,898.20 |
| 69           | 1,406.40 | 1,654.60 | 1,860.50 | 1,687.70 | 69         | 1,638.90 | 1,928.20 | 2,076.10 | 1,966.60 |
| 70           | 1,444.20 | 1,699.00 | 1,902.60 | 1,732.90 | 70         | 1,691.30 | 1,989.80 | 2,128.40 | 2,029.60 |
| 71           | 1,481.30 | 1,742.60 | 1,945.80 | 1,777.50 | 71         | 1,743.30 | 2,051.00 | 2,182.30 | 2,092.00 |
| 72           | 1,519.40 | 1,787.50 | 1,989.10 | 1,823.20 | 72         | 1,792.70 | 2,109.00 | 2,242.00 | 2,151.20 |
| 73           | 1,557.90 | 1,832.80 | 2,033.60 | 1,869.40 | 73         | 1,842.70 | 2,167.80 | 2,303.60 | 2,211.20 |
| 74           | 1,588.10 | 1,868.30 | 2,072.00 | 1,905.70 | 74         | 1,887.80 | 2,220.90 | 2,358.80 | 2,265.30 |
| 75           | 1,618.30 | 1,903.90 | 2,110.70 | 1,942.00 | 75         | 1,933.40 | 2,274.60 | 2,414.80 | 2,320.20 |
| 76           | 1,643.20 | 1,933.20 | 2,143.10 | 1,971.80 | 76         | 1,972.90 | 2,321.10 | 2,464.10 | 2,367.60 |
| 77           | 1,669.20 | 1,963.70 | 2,174.30 | 2,003.00 | 77         | 2,009.10 | 2,363.70 | 2,501.10 | 2,410.90 |
| 78           | 1,695.10 | 1,994.30 | 2,206.80 | 2,034.10 | 78         | 2,045.50 | 2,406.40 | 2,538.60 | 2,454.50 |
| 79           | 1,711.90 | 2,013.90 | 2,234.40 | 2,054.30 | 79         | 2,076.10 | 2,442.50 | 2,576.70 | 2,491.30 |
| 80           | 1,728.90 | 2,034.00 | 2,262.10 | 2,074.70 | 80         | 2,107.20 | 2,479.10 | 2,615.30 | 2,528.80 |
| 81           | 1,746.10 | 2,054.20 | 2,283.70 | 2,095.30 | 81         | 2,138.90 | 2,516.30 | 2,654.50 | 2,566.60 |
| 82           | 1,763.40 | 2,074.60 | 2,304.20 | 2,116.10 | 82         | 2,170.90 | 2,554.10 | 2,694.30 | 2,605.10 |
| 83           | 1,780.90 | 2,095.20 | 2,325.80 | 2,137.00 | 83         | 2,203.50 | 2,592.40 | 2,734.70 | 2,644.20 |
| 84           | 1,798.50 | 2,116.00 | 2,346.30 | 2,158.30 | 84         | 2,236.60 | 2,631.30 | 2,775.80 | 2,683.90 |
| 85+          | 1,816.40 | 2,137.00 | 2,366.80 | 2,179.70 | 85+        | 2,270.10 | 2,670.80 | 2,817.40 | 2,724.20 |

Annual Premium Conversion Formulas  
Semi-Annual - Annual x .525, Quarterly - Annual x .2625,  
Monthly PAC - Annual x .085

Add \$15 Policy Fee (non-commissionable, non-refundable) to first premium payment.

\*On Medicare due to disability.

**Conseco Insurance Company**  
**State of Missouri**  
Form CIC-1000 Issue Age - Preferred Risk  
Gross Premiums -- AREA D  
Zip Codes (635-636, 642-647, 650-653)

**2006 Annual Rates**

| Female Rates |          |          |          |          | Male Rates |          |          |          |          |
|--------------|----------|----------|----------|----------|------------|----------|----------|----------|----------|
| Issue Age    | Plan A   | Plan D   | Plan F   | Plan G   | Issue Age  | Plan A   | Plan D   | Plan F   | Plan G   |
| Under 65*    | 1,405.90 | 1,654.00 | 1,840.60 | 1,644.80 | Under 65*  | 1,658.90 | 1,897.80 | 2,074.60 | 1,692.90 |
| 65           | 1,158.90 | 1,363.50 | 1,624.10 | 1,390.80 | 65         | 1,310.90 | 1,542.20 | 1,723.80 | 1,573.10 |
| 66           | 1,193.30 | 1,404.00 | 1,648.00 | 1,432.00 | 66         | 1,359.80 | 1,599.90 | 1,771.00 | 1,631.90 |
| 67           | 1,228.90 | 1,445.70 | 1,672.40 | 1,474.60 | 67         | 1,410.80 | 1,659.80 | 1,819.90 | 1,692.90 |
| 68           | 1,265.60 | 1,488.80 | 1,696.20 | 1,518.60 | 68         | 1,463.80 | 1,722.10 | 1,869.20 | 1,756.50 |
| 69           | 1,301.40 | 1,531.00 | 1,721.50 | 1,561.70 | 69         | 1,516.40 | 1,784.20 | 1,921.00 | 1,819.80 |
| 70           | 1,336.40 | 1,572.20 | 1,760.40 | 1,603.60 | 70         | 1,565.00 | 1,841.20 | 1,969.50 | 1,878.00 |
| 71           | 1,370.70 | 1,612.50 | 1,800.50 | 1,644.80 | 71         | 1,613.20 | 1,897.80 | 2,019.30 | 1,935.80 |
| 72           | 1,405.90 | 1,654.00 | 1,840.60 | 1,687.10 | 72         | 1,658.90 | 1,951.50 | 2,074.60 | 1,990.60 |
| 73           | 1,441.50 | 1,695.90 | 1,881.80 | 1,729.80 | 73         | 1,705.00 | 2,006.00 | 2,131.60 | 2,046.10 |
| 74           | 1,469.50 | 1,728.80 | 1,917.40 | 1,763.30 | 74         | 1,746.70 | 2,055.10 | 2,182.60 | 2,096.10 |
| 75           | 1,497.50 | 1,761.70 | 1,953.00 | 1,797.00 | 75         | 1,789.10 | 2,104.70 | 2,234.50 | 2,146.80 |
| 76           | 1,520.50 | 1,788.80 | 1,982.90 | 1,824.60 | 76         | 1,825.50 | 2,147.80 | 2,280.10 | 2,190.70 |
| 77           | 1,544.50 | 1,817.10 | 2,012.00 | 1,853.40 | 77         | 1,859.10 | 2,187.20 | 2,314.30 | 2,230.80 |
| 78           | 1,568.50 | 1,845.30 | 2,042.00 | 1,882.20 | 78         | 1,892.70 | 2,226.70 | 2,348.90 | 2,271.30 |
| 79           | 1,584.10 | 1,863.60 | 2,067.60 | 1,900.90 | 79         | 1,921.10 | 2,260.10 | 2,384.20 | 2,305.30 |
| 80           | 1,599.80 | 1,882.10 | 2,093.20 | 1,919.80 | 80         | 1,949.90 | 2,294.00 | 2,420.00 | 2,339.90 |
| 81           | 1,615.70 | 1,900.80 | 2,113.20 | 1,938.80 | 81         | 1,979.10 | 2,328.50 | 2,456.20 | 2,375.00 |
| 82           | 1,631.70 | 1,919.70 | 2,132.10 | 1,958.00 | 82         | 2,008.90 | 2,363.30 | 2,493.10 | 2,410.60 |
| 83           | 1,647.90 | 1,938.70 | 2,152.20 | 1,977.50 | 83         | 2,039.00 | 2,398.70 | 2,530.60 | 2,446.70 |
| 84           | 1,664.20 | 1,957.90 | 2,171.10 | 1,997.10 | 84         | 2,069.50 | 2,434.70 | 2,568.50 | 2,483.40 |
| 85+          | 1,680.80 | 1,977.30 | 2,190.00 | 2,017.00 | 85+        | 2,100.60 | 2,471.30 | 2,607.00 | 2,520.70 |

Annual Premium Conversion Formulas  
Semi-Annual - Annual x .525, Quarterly - Annual x .2625,  
Monthly PAC - Annual x .085

Add \$15 Policy Fee (non-commissionable, non-refundable) to first premium payment.

\*On Medicare due to disability.

**Conseco Insurance Company**  
**State of Missouri**  
Form CIC-1000 Issue Age - Standard Risk  
Gross Premiums -- AREA D  
Zip Codes (635-636, 642-647, 650-653)

**2006 Annual Rates**

| Female Rates |          |          |          |          | Male Rates |          |          |          |          |
|--------------|----------|----------|----------|----------|------------|----------|----------|----------|----------|
| Issue Age    | Plan A   | Plan D   | Plan F   | Plan G   | Issue Age  | Plan A   | Plan D   | Plan F   | Plan G   |
| Under 65*    | 1,654.00 | 1,945.80 | 2,165.40 | 1,935.00 | Under 65*  | 1,951.50 | 2,232.70 | 2,375.70 | 1,902.10 |
| 65           | 1,158.90 | 1,363.50 | 1,624.10 | 1,390.80 | 65         | 1,310.90 | 1,542.20 | 1,723.80 | 1,573.10 |
| 66           | 1,268.90 | 1,492.90 | 1,722.00 | 1,522.70 | 66         | 1,448.00 | 1,703.50 | 1,848.80 | 1,737.50 |
| 67           | 1,378.90 | 1,622.20 | 1,819.80 | 1,654.60 | 67         | 1,585.10 | 1,864.70 | 1,974.00 | 1,902.10 |
| 68           | 1,488.80 | 1,751.60 | 1,995.50 | 1,786.70 | 68         | 1,722.10 | 2,026.00 | 2,199.00 | 2,066.40 |
| 69           | 1,531.00 | 1,801.20 | 2,025.30 | 1,837.20 | 69         | 1,784.20 | 2,099.00 | 2,260.10 | 2,140.90 |
| 70           | 1,572.20 | 1,849.50 | 2,071.10 | 1,886.50 | 70         | 1,841.20 | 2,166.10 | 2,317.00 | 2,209.40 |
| 71           | 1,612.50 | 1,897.00 | 2,118.30 | 1,935.00 | 71         | 1,897.80 | 2,232.70 | 2,375.70 | 2,277.40 |
| 72           | 1,654.00 | 1,945.80 | 2,165.40 | 1,984.80 | 72         | 1,951.50 | 2,295.90 | 2,440.70 | 2,341.90 |
| 73           | 1,695.90 | 1,995.20 | 2,213.80 | 2,035.00 | 73         | 2,006.00 | 2,359.90 | 2,507.70 | 2,407.10 |
| 74           | 1,728.80 | 2,033.80 | 2,255.60 | 2,074.60 | 74         | 2,055.10 | 2,417.70 | 2,567.80 | 2,466.10 |
| 75           | 1,761.70 | 2,072.60 | 2,297.70 | 2,114.10 | 75         | 2,104.70 | 2,476.10 | 2,628.80 | 2,525.70 |
| 76           | 1,788.80 | 2,104.50 | 2,333.00 | 2,146.60 | 76         | 2,147.80 | 2,526.80 | 2,682.40 | 2,577.30 |
| 77           | 1,817.10 | 2,137.70 | 2,367.00 | 2,180.50 | 77         | 2,187.20 | 2,573.10 | 2,722.70 | 2,624.50 |
| 78           | 1,845.30 | 2,171.00 | 2,402.30 | 2,214.30 | 78         | 2,226.70 | 2,619.60 | 2,763.50 | 2,672.00 |
| 79           | 1,863.60 | 2,192.40 | 2,432.40 | 2,236.30 | 79         | 2,260.10 | 2,658.90 | 2,805.00 | 2,712.10 |
| 80           | 1,882.10 | 2,214.20 | 2,462.50 | 2,258.50 | 80         | 2,294.00 | 2,698.80 | 2,847.00 | 2,752.90 |
| 81           | 1,900.80 | 2,236.20 | 2,486.10 | 2,281.00 | 81         | 2,328.50 | 2,739.30 | 2,889.70 | 2,794.10 |
| 82           | 1,919.70 | 2,258.40 | 2,508.40 | 2,303.60 | 82         | 2,363.30 | 2,780.40 | 2,933.00 | 2,835.90 |
| 83           | 1,938.70 | 2,280.90 | 2,531.90 | 2,326.40 | 83         | 2,398.70 | 2,822.10 | 2,977.10 | 2,878.50 |
| 84           | 1,957.90 | 2,303.50 | 2,554.20 | 2,349.50 | 84         | 2,434.70 | 2,864.40 | 3,021.80 | 2,921.70 |
| 85+          | 1,977.30 | 2,326.30 | 2,576.50 | 2,372.80 | 85+        | 2,471.30 | 2,907.40 | 3,067.00 | 2,965.50 |

Annual Premium Conversion Formulas  
Semi-Annual - Annual x .525, Quarterly - Annual x .2625,  
Monthly PAC - Annual x .085

Add \$15 Policy Fee (non-commissionable, non-refundable) to first premium payment.

\*On Medicare due to disability.

**Conseco Insurance Company**  
**State of Missouri**  
Form CIC-1000 Issue Age - Preferred Risk  
Gross Premiums -- AREA F  
Zip Codes (630-633, 640-641, 649)

**2006 Annual Rates**

| Female Rates |          |          |          |          | Male Rates |          |          |          |          |
|--------------|----------|----------|----------|----------|------------|----------|----------|----------|----------|
| Issue Age    | Plan A   | Plan D   | Plan F   | Plan G   | Issue Age  | Plan A   | Plan D   | Plan F   | Plan G   |
| Under 65*    | 1,634.80 | 1,923.30 | 2,140.20 | 1,912.50 | Under 65*  | 1,928.90 | 2,206.70 | 2,412.30 | 1,968.50 |
| 65           | 1,347.60 | 1,585.50 | 1,888.50 | 1,617.20 | 65         | 1,524.30 | 1,793.20 | 2,004.40 | 1,829.20 |
| 66           | 1,387.60 | 1,632.50 | 1,916.30 | 1,665.10 | 66         | 1,581.20 | 1,860.30 | 2,059.30 | 1,897.50 |
| 67           | 1,428.90 | 1,681.00 | 1,944.70 | 1,714.70 | 67         | 1,640.50 | 1,930.00 | 2,116.20 | 1,968.50 |
| 68           | 1,471.60 | 1,731.20 | 1,972.30 | 1,765.80 | 68         | 1,702.10 | 2,002.40 | 2,173.50 | 2,042.40 |
| 69           | 1,513.20 | 1,780.20 | 2,001.80 | 1,815.90 | 69         | 1,763.30 | 2,074.60 | 2,233.70 | 2,116.00 |
| 70           | 1,553.90 | 1,828.10 | 2,047.00 | 1,864.60 | 70         | 1,819.80 | 2,140.90 | 2,290.10 | 2,183.70 |
| 71           | 1,593.80 | 1,875.00 | 2,093.60 | 1,912.50 | 71         | 1,875.80 | 2,206.70 | 2,348.00 | 2,250.90 |
| 72           | 1,634.80 | 1,923.30 | 2,140.20 | 1,961.70 | 72         | 1,928.90 | 2,269.20 | 2,412.30 | 2,314.60 |
| 73           | 1,676.20 | 1,972.00 | 2,188.10 | 2,011.40 | 73         | 1,982.60 | 2,332.50 | 2,478.60 | 2,379.20 |
| 74           | 1,708.70 | 2,010.20 | 2,229.50 | 2,050.40 | 74         | 2,031.10 | 2,389.60 | 2,537.90 | 2,437.30 |
| 75           | 1,741.30 | 2,048.50 | 2,270.90 | 2,089.50 | 75         | 2,080.30 | 2,447.30 | 2,598.20 | 2,496.30 |
| 76           | 1,768.00 | 2,080.00 | 2,305.70 | 2,121.60 | 76         | 2,122.70 | 2,497.40 | 2,651.30 | 2,547.30 |
| 77           | 1,795.90 | 2,112.90 | 2,339.50 | 2,155.10 | 77         | 2,161.70 | 2,543.20 | 2,691.00 | 2,594.00 |
| 78           | 1,823.80 | 2,145.70 | 2,374.40 | 2,188.60 | 78         | 2,200.80 | 2,589.20 | 2,731.30 | 2,641.00 |
| 79           | 1,842.00 | 2,167.00 | 2,404.20 | 2,210.30 | 79         | 2,233.80 | 2,628.00 | 2,772.30 | 2,680.60 |
| 80           | 1,860.20 | 2,188.50 | 2,433.90 | 2,232.30 | 80         | 2,267.30 | 2,667.40 | 2,813.90 | 2,720.80 |
| 81           | 1,878.70 | 2,210.20 | 2,457.20 | 2,254.40 | 81         | 2,301.30 | 2,707.50 | 2,856.10 | 2,761.60 |
| 82           | 1,897.30 | 2,232.20 | 2,479.20 | 2,276.70 | 82         | 2,335.90 | 2,748.00 | 2,899.00 | 2,803.00 |
| 83           | 1,916.20 | 2,254.30 | 2,502.50 | 2,299.40 | 83         | 2,370.90 | 2,789.20 | 2,942.50 | 2,845.00 |
| 84           | 1,935.10 | 2,276.60 | 2,524.50 | 2,322.20 | 84         | 2,406.40 | 2,831.10 | 2,986.60 | 2,887.70 |
| 85+          | 1,954.40 | 2,299.20 | 2,546.50 | 2,345.30 | 85+        | 2,442.50 | 2,873.60 | 3,031.40 | 2,931.00 |

Annual Premium Conversion Formulas  
Semi-Annual - Annual x .525, Quarterly - Annual x .2625,  
Monthly PAC - Annual x .085

Add \$15 Policy Fee (non-commissionable, non-refundable) to first premium payment.

\*On Medicare due to disability.

**Conseco Insurance Company**  
**State of Missouri**  
Form CIC-1000 Issue Age - Standard Risk  
Gross Premiums -- AREA F  
Zip Codes (630-633, 640-641, 649)

**2006 Annual Rates**

| Female Rates |          |          |          |          | Male Rates |          |          |          |          |
|--------------|----------|----------|----------|----------|------------|----------|----------|----------|----------|
| Issue Age    | Plan A   | Plan D   | Plan F   | Plan G   | Issue Age  | Plan A   | Plan D   | Plan F   | Plan G   |
| Under 65*    | 1,923.30 | 2,262.60 | 2,517.90 | 2,250.00 | Under 65*  | 2,269.20 | 2,596.20 | 2,762.40 | 2,211.70 |
| 65           | 1,347.60 | 1,585.50 | 1,888.50 | 1,617.20 | 65         | 1,524.30 | 1,793.20 | 2,004.40 | 1,829.20 |
| 66           | 1,475.50 | 1,735.90 | 2,002.30 | 1,770.60 | 66         | 1,683.70 | 1,980.80 | 2,149.80 | 2,020.40 |
| 67           | 1,603.40 | 1,886.30 | 2,116.00 | 1,924.00 | 67         | 1,843.10 | 2,168.30 | 2,295.40 | 2,211.70 |
| 68           | 1,731.20 | 2,036.70 | 2,320.30 | 2,077.50 | 68         | 2,002.40 | 2,355.80 | 2,557.00 | 2,402.80 |
| 69           | 1,780.20 | 2,094.40 | 2,355.00 | 2,136.30 | 69         | 2,074.60 | 2,440.70 | 2,628.00 | 2,489.40 |
| 70           | 1,828.10 | 2,150.60 | 2,408.30 | 2,193.60 | 70         | 2,140.90 | 2,518.70 | 2,694.20 | 2,569.10 |
| 71           | 1,875.00 | 2,205.80 | 2,463.10 | 2,250.00 | 71         | 2,206.70 | 2,596.20 | 2,762.40 | 2,648.10 |
| 72           | 1,923.30 | 2,262.60 | 2,517.90 | 2,307.90 | 72         | 2,269.20 | 2,669.60 | 2,838.00 | 2,723.10 |
| 73           | 1,972.00 | 2,320.00 | 2,574.20 | 2,366.30 | 73         | 2,332.50 | 2,744.10 | 2,915.90 | 2,799.00 |
| 74           | 2,010.20 | 2,364.90 | 2,622.80 | 2,412.30 | 74         | 2,389.60 | 2,811.30 | 2,985.80 | 2,867.50 |
| 75           | 2,048.50 | 2,410.00 | 2,671.80 | 2,458.20 | 75         | 2,447.30 | 2,879.20 | 3,056.70 | 2,936.90 |
| 76           | 2,080.00 | 2,447.10 | 2,712.80 | 2,496.00 | 76         | 2,497.40 | 2,938.10 | 3,119.10 | 2,996.90 |
| 77           | 2,112.90 | 2,485.70 | 2,752.30 | 2,535.50 | 77         | 2,543.20 | 2,992.00 | 3,165.90 | 3,051.80 |
| 78           | 2,145.70 | 2,524.40 | 2,793.40 | 2,574.80 | 78         | 2,589.20 | 3,046.10 | 3,213.40 | 3,107.00 |
| 79           | 2,167.00 | 2,549.30 | 2,828.40 | 2,600.40 | 79         | 2,628.00 | 3,091.80 | 3,261.60 | 3,153.60 |
| 80           | 2,188.50 | 2,574.70 | 2,863.40 | 2,626.20 | 80         | 2,667.40 | 3,138.10 | 3,310.50 | 3,201.00 |
| 81           | 2,210.20 | 2,600.20 | 2,890.80 | 2,652.30 | 81         | 2,707.50 | 3,185.20 | 3,360.10 | 3,248.90 |
| 82           | 2,232.20 | 2,626.10 | 2,916.70 | 2,678.60 | 82         | 2,748.00 | 3,233.00 | 3,410.50 | 3,297.60 |
| 83           | 2,254.30 | 2,652.20 | 2,944.10 | 2,705.10 | 83         | 2,789.20 | 3,281.50 | 3,461.70 | 3,347.10 |
| 84           | 2,276.60 | 2,678.50 | 2,970.00 | 2,732.00 | 84         | 2,831.10 | 3,330.70 | 3,513.70 | 3,397.30 |
| 85+          | 2,299.20 | 2,705.00 | 2,995.90 | 2,759.10 | 85+        | 2,873.60 | 3,380.70 | 3,566.30 | 3,448.30 |

Annual Premium Conversion Formulas  
Semi-Annual - Annual x .525, Quarterly - Annual x .2625,  
Monthly PAC - Annual x .085

Add \$15 Policy Fee (non-commissionable, non-refundable) to first premium payment.

\*On Medicare due to disability.

### **PREMIUM INFORMATION**

Benefits provided by your policy are tied to Medicare's deductible amounts and coinsurance amounts, which may change on an annual basis. Premium rates and benefit changes are expected to occur each year to adjust for changes in Medicare and medical inflation. We, **CONSECO INSURANCE COMPANY**, will only change your premium if we change it for all policies like yours in your state of issue on a class basis. This outline of coverage includes the original schedule of premiums. For more information on our right to change your schedule of premiums, please refer to the RIGHT TO CHANGE RATES provision on page one of the policy.

### **DISCLOSURES**

Use this outline to compare benefits and premiums among policies.

### **READ YOUR POLICY VERY CAREFULLY**

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

### **RIGHT TO RETURN POLICY**

If you find that you are not satisfied with your policy, you may return it to Conseco Insurance Company, Administrative Office, 11815 North Pennsylvania Street, Carmel, IN 46032. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

### **POLICY REPLACEMENT**

If you are replacing another health insurance policy, DO NOT cancel it until you have actually received your new policy and are sure you want to keep it.

### **NOTICE**

This policy may not fully cover all of your medical costs.

Neither CONSECO INSURANCE COMPANY nor its insurance producers are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare and You" for more details.

### **COMPLETE ANSWERS ARE VERY IMPORTANT**

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

**PLANS A  
MEDICARE (PART A) HOSPITAL SERVICES - PER BENEFIT PERIOD**

\* A benefit period begins on the first day you receive services 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   |   |
|---|---|--|---|
|   |   | PLAN A PAYS  | YOU PAY   |
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies<br>First 60 days<br>61st thru 90th day<br>91st day and after<br>While using 60 lifetime reserve days<br>Once lifetime reserve days are used: Additional 365 days<br><br>Beyond the Additional 365 days | All but \$952<br>All but \$238 a day<br>All but \$476 a day<br><br>\$0<br><br>\$0 | \$0<br>\$238 a day<br>\$476 a day<br><br>100% of Medicare Eligible Expenses<br>\$0 | \$952 (Part A Deductible)<br>\$0<br>\$0<br>\$0**<br>All Costs |
| <b>SKILLED NURSING FACILITY CARE*</b><br>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<br>First 20 days<br>21st thru 100th day<br>101st day and after                             | All approved amounts<br>All but \$119 a day<br>\$0                                | \$0<br>\$0<br>\$0  | \$0<br>Up to \$119 a day<br>All Costs                         |
| <b>BLOOD</b><br>First 3 Pints<br>Additional amounts   | \$0<br>100%   | 3 pints<br>\$0   | \$0<br>\$0  |
| <b>HOSPICE CARE</b><br>Available as long as your doctor certifies you are terminally ill and you elect to receive these services  | All but very limited coinsurance for out-patient drugs and inpatient respite care | \$0  | Balance   |

\*\*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.

**PLANS A  
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\* Once you have been billed \$124 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

| SERVICES  | MEDICARE PAYS  | PLAN A         |                          |
|---|----------------|----------------|--------------------------|
|   |                | PLAN A PAYS    | YOU PAY                  |
| <b>MEDICAL EXPENSES</b> - 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 test, durable medical equipment |                |                |                          |
| First \$124 of Medicare Approved Amounts*   | \$0            | \$0            | \$124(Part B Deductible) |
| Remainder of Medicare Approved Amounts  | Generally, 80% | Generally, 20% | \$0                      |
| <b>Part B Excess Charges</b> (Above Medicare Approved Amounts)  | \$0            | \$0            | All Costs                |
| <b>BLOOD</b>  |                |                |                          |
| First 3 pints   | \$0            | All Costs      | \$0                      |
| Next \$124 of Medicare Approved Amounts*  | \$0            | \$0            | \$124(Part B Deductible) |
| Remainder of Medicare Approved Amounts  | 80%            | 20%            | \$0                      |
| <b>CLINICAL LABORATORY SERVICES</b> - TESTS FOR DIAGNOSTIC SERVICES   | 100%           | \$0            | \$0                      |

**MEDICARE PARTS A & B**

|  |      |     |                          |
|--|------|-----|--------------------------|
| <b>HOME HEALTH CARE</b>  |      |     |                          |
| MEDICARE APPROVED SERVICES                                     |      |     |                          |
| Medically necessary skilled care services and medical supplies | 100% | \$0 | \$0                      |
| Durable medical equipment                                      | \$0  | \$0 | \$124(Part B Deductible) |
| First \$124 of Medicare Approved Amounts*                      |      |     |                          |
| Remainder of Medicare Approved Amounts                         | 80%  | 20% | \$0                      |

**PLAN D  
MEDICARE (PART A) HOSPITAL SERVICES - PER BENEFIT PERIOD**

\*A benefit period begins on the first day you receive services 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 D   |   |
|---|---|--|---|
|   |   | PLAN D PAYS  | YOU PAY   |
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days<br>61st thru 90th day<br>91st day and after<br>While using 60 lifetime reserve days<br>Once lifetime reserve days are used: Additional 365 days<br><br>Beyond the Additional 365 days | All but \$952<br>All but \$238 a day<br><br>All but \$476 a day<br>\$0<br><br>\$0 | \$952 (Part A Deductible)<br>\$238 a day<br><br>\$476 a day<br>100% of Medicare Eligible Expenses<br>\$0 | \$0<br>\$0<br><br>\$0<br>\$0**<br><br>All Costs |
| <b>SKILLED NURSING FACILITY CARE*</b><br>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<br>21st thru 100th day<br>101st day and after                             | All approved amounts<br>All but \$119 a day<br>\$0                                | \$0<br>Up to \$119 a day<br>\$0  | \$0<br>\$0<br>All Costs                         |
| <b>BLOOD</b><br>First 3 Pints<br>Additional amounts   | \$0<br>100%   | 3 pints<br>\$0   | \$0<br>\$0                                      |
| <b>HOSPICE CARE</b><br>Available as long as your doctor certifies you are terminally ill and you elect to receive these services  | All but very limited coinsurance for out-patient drugs and inpatient respite care | \$0  | Balance   |

\*\*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.

**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed \$124 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

| SERVICES  | MEDICARE PAYS  | PLAN D         |                          |
|---|----------------|----------------|--------------------------|
|   |                | PLAN D PAYS    | YOU PAY                  |
| <b>MEDICAL EXPENSES</b> – In or Out of the Hospital and Out Patient Hospital Treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment<br>First \$124 of Medicare Approved Amounts* | \$0            | \$0            | \$124(Part B Deductible) |
| Remainder of Medicare Approved Amounts  | Generally, 80% | Generally, 20% | \$0                      |
| <b>Part B Excess Charges</b> (Above Medicare Approved Amounts)  | \$0            | \$0            | All Costs                |

**PLAN D**  
**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR (Continued)**

| SERVICES  | MEDICARE PAYS | PLAN D      |                          |
|---|---------------|-------------|--------------------------|
|   |               | PLAN D PAYS | YOU PAY                  |
| <b>BLOOD:</b> First 3 pints   | \$0           | All Costs   | \$0                      |
| Next \$124 of Medicare Approved Amounts*                            | \$0           | \$0         | \$124(Part B Deductible) |
| Remainder of Medicare Approved Amounts                              | 80%           | 20%         | \$0                      |
| <b>CLINICAL LABORATORY SERVICES</b> - Tests For Diagnostic Services | 100%          | \$0         | \$0                      |

**MEDICARE PARTS A & B**

|  |      |  |                          |
|--|------|--|--------------------------|
| <b>HOME HEALTH CARE</b> – Medicare Approved Services   |      |  |                          |
| Medically necessary skilled care services and medical supplies   | 100% | \$0  | \$0                      |
| Durable medical equipment: First \$124 of Medicare Approved Amounts*   | \$0  | \$0  | \$124(Part B Deductible) |
| Remainder of Medicare Approved Amounts   | 80%  | 20%  | \$0                      |
| <b>AT-HOME RECOVERY SERVICES</b> - Not Covered By Medicare   |      |  |                          |
| Home care certified by your doctor, for personal care during recovery from any injury or sickness for which Medicare approved a Home Care Treatment Plan |      |  |                          |
| Benefit for each visit   | \$0  | Actual Charges to \$40 a visit   | Balance                  |
| Number of visits covered (must Be received within 8 weeks of last Medicare Approved visit)   | \$0  | Up to the number of Medicare Approved visits not to exceed 7 each week | Balance                  |
| Calendar year maximum  | \$0  | \$1600   | Balance                  |

**OTHER BENEFITS NOT COVERED BY MEDICARE**

|  |     |                                       |  |
|--|-----|---------------------------------------|--|
| <b>FOREIGN TRAVEL</b> - Not Covered By Medicare  |     |                                       |  |
| Medically necessary emergency 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 of \$50,000 | 20% and amounts over \$50,000 lifetime maximum |

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

**PLAN F  
MEDICARE (PART A) HOSPITAL SERVICES - PER BENEFIT PERIOD**

\* A benefit period begins on the first day you receive services 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.

\*\* This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$1790 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$1790. Out-of-pocket expenses for this deductible are expenses 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.

| SERVICES  | MEDICARE PAYS   | PLAN F or HIGH DEDUCTIBLE PLAN F**   |  |
|---|---|--|--|
|   |   | PLAN F PAYS  | YOU PAY                                  |
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies<br>First 60 days<br>61st thru 90th day<br>91st day and after<br>While using 60 lifetime reserve days<br>Once lifetime reserve days are used: Additional 365 days<br>Beyond the Additional 365 days | All but \$952<br>All but \$238 a day<br>All but \$476 a day<br>\$0<br>\$0         | \$952 (Part A Deductible)<br>\$238 a day<br>\$476 a day<br>100% of Medicare Eligible Expenses<br>\$0 | \$0<br>\$0<br>\$0<br>\$0***<br>All Costs |
| <b>SKILLED NURSING FACILITY CARE*</b><br>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<br>First 20 days<br>21st thru 100th day<br>101st day and after                         | All approved amounts<br>All but \$119 a day<br>\$0                                | \$0<br>Up to \$119 a day<br>\$0  | \$0<br>\$0<br>All Costs                  |
| <b>BLOOD</b><br>First 3 Pints<br>Additional amounts   | \$0<br>100%   | 3 pints<br>\$0   | \$0<br>\$0                               |
| <b>HOSPICE CARE</b><br>Available as long as your doctor certifies you are terminally ill and you elect to receive these services  | All but very limited coinsurance for out-patient drugs and inpatient respite care | \$0  | Balance                                  |

\*\*\*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 F  
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\* Once you have been billed \$124 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

\*\* This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$1790 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$1790. Out-of-pocket expenses for this deductible are expenses 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.

| SERVICES  | MEDICARE PAYS  | PLAN F or HIGH DEDUCTIBLE PLAN F** |         |
|---|----------------|------------------------------------|---------|
|   |                | PLAN F PAYS                        | YOU PAY |
| <b>MEDICAL EXPENSES</b> - 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 test, durable medical equipment | \$0            | \$124(Part B Deductible)           | \$0     |
| First \$124 of Medicare Approved Amounts*   | Generally, 80% | Generally, 20%                     | \$0     |
| Remainder of Medicare Approved Amounts  |                |                                    |         |
| <b>Part B Excess Charges</b> (Above Medicare Approved Amounts)  | \$0            | 100%                               | \$0     |
| <b>BLOOD</b>  |                |                                    |         |
| First 3 pints   | \$0            | All Costs                          | \$0     |
| Next \$124 of Medicare Approved Amounts*  | \$0            | \$124(Part B Deductible)           | \$0     |
| Remainder of Medicare Approved Amounts  | 80%            | 20%                                | \$0     |
| <b>CLINICAL LABORATORY SERVICES</b> - TESTS FOR DIAGNOSTIC SERVICES   | 100%           | \$0                                | \$0     |

**MEDICARE PARTS A & B**

|  |      |                           |     |
|--|------|---------------------------|-----|
| <b>HOME HEALTH CARE</b>  |      |                           |     |
| MEDICARE APPROVED SERVICES                                     |      |                           |     |
| Medically necessary skilled care services and medical supplies | 100% | \$0                       | \$0 |
| Durable medical equipment                                      | \$0  | \$124 (Part B Deductible) | \$0 |
| First \$124 of Medicare Approved Amounts*                      |      |                           |     |
| Remainder of Medicare Approved Amounts                         | 80%  | 20%                       | \$0 |

**OTHER BENEFITS NOT COVERED BY MEDICARE**

|   |     |                                       |  |
|---|-----|---------------------------------------|--|
| <b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b>   |     |                                       |  |
| 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 of \$50,000 | 20% and amounts over \$50,000 lifetime maximum |

**PLAN G  
MEDICARE (PART A) HOSPITAL SERVICES - PER BENEFIT PERIOD**

\*A benefit period begins on the first day you receive services 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   |   |
|---|---|--|---|
|   |   | PLAN G PAYS  | YOU PAY                                     |
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days<br>61st thru 90th day<br>91st day and after<br>While using 60 lifetime reserve days<br>Once lifetime reserve days are used: Additional 365 days<br><br>Beyond the Additional 365 days | All but \$952<br>All but \$238 a day<br>All but \$476 a day<br><br>\$0<br>\$0     | \$952 (Part A Deductible)<br>\$238 a day<br>\$476 a day<br><br>100% of Medicare Eligible Expenses<br>\$0 | \$0<br>\$0<br>\$0<br><br>\$0**<br>All Costs |
| <b>SKILLED NURSING FACILITY CARE*</b><br>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<br>First 20 days<br>21st thru 100th day<br>101st day and after                           | All approved amounts<br>All but \$119 a day<br>\$0                                | \$0<br>Up to \$119 a day<br>\$0  | \$0<br>\$0<br>All Costs                     |
| <b>BLOOD</b><br>First 3 Pints<br>Additional amounts   | \$0<br>100%   | 3 pints<br>\$0   | \$0<br>\$0                                  |
| <b>HOSPICE CARE</b><br>Available as long as your doctor certifies you are terminally ill and you elect to receive these services  | All but very limited coinsurance for out-patient drugs and inpatient respite care | \$0  | Balance                                     |

\*\*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.

**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed \$124 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

| SERVICES  | MEDICARE PAYS         | PLAN G                |                                 |
|---|-----------------------|-----------------------|---------------------------------|
|   |                       | PLAN G PAYS           | YOU PAY                         |
| <b>MEDICAL EXPENSES</b> - In or Out Of The Hospital And Out Patient Hospital Treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment: First \$124 of Medicare Approved Amounts*<br>Remainder of Medicare Approved Amounts | \$0<br>Generally, 80% | \$0<br>Generally, 20% | \$124(Part B Deductible)<br>\$0 |
| <b>Part B Excess Charges</b> (Above Medicare Approved Amounts)  | \$0                   | 80%                   | 20%                             |

**PLAN G**  
**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR (Continued)**

| SERVICES  | MEDICARE PAYS | PLAN G   |  |
|---|---------------|--|--|
|   |               | PLAN G PAYS  | YOU PAY  |
| <b>BLOOD:</b> First 3 pints   | \$0           | All Costs  | \$0  |
| Next \$124 of Medicare Approved Amounts*  | \$0           | \$0  | \$124(Part B Deductible)                       |
| Remainder of Medicare Approved Amounts  | 80%           | 20%  | \$0  |
| <b>CLINICAL LABORATORY SERVICES</b> –Tests for Diagnostic Services  | 100%          | \$0  | \$0  |
| <b>MEDICARE PARTS A &amp; B</b>   |               |  |  |
| <b>HOME HEALTH CARE</b> Medicare Approved Services<br>Medically necessary skilled care services and medical supplies  | 100%          | \$0  | \$0  |
| Durable medical equipment   |               |  | \$124(Part B Deductible)                       |
| First \$124 of Medicare Approved Amounts*   | \$0           | \$0  |  |
| Remainder of Medicare Approved Amounts  | 80%           | 20%  | \$0  |
| <b>AT-HOME RECOVERY SERVICES</b> – Not Covered By Medicare<br>Home care certified by your doctor, for personal care during recovery from any injury or sickness for which Medicare approved a Home Care Treatment Plan: |               |  |  |
| Benefit for each visit  | \$0           | Actual Charges to \$40 a visit   | Balance  |
| Number of visits covered (must Be received within 8 weeks of last Medicare Approved visit)  | \$0           | Up to the number of Medicare Approved visits not to exceed 7 each week | Balance  |
| Calendar year maximum   | \$0           | \$1600   | Balance  |
| <b>OTHER BENEFITS NOT COVERED BY MEDICARE</b>   |               |  |  |
| <b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b><br>Medically necessary emergency 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 of \$50,000                                  | 20% and amounts over \$50,000 lifetime maximum |

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

**Medicare supplement**  
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*Policy form: CIC-1000*

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