

SERFF Tracking Number: ELCC-126393227 State: Arkansas
Filing Company: Equitable Life & Casualty Insurance Company State Tracking Number: 44518
Company Tracking Number: 790
TOI: H131 Individual Health - Short Term Care Sub-TOI: H131.002 Nursing Home
Product Name: EquiCare 790
Project Name/Number: 790/790

Filing at a Glance

Company: Equitable Life & Casualty Insurance Company

Product Name: EquiCare 790

SERFF Tr Num: ELCC-126393227 State: Arkansas

TOI: H131 Individual Health - Short Term Care

SERFF Status: Closed-Approved-
Closed State Tr Num: 44518

Sub-TOI: H131.002 Nursing Home

Co Tr Num: 790

State Status: Approved-Closed

Filing Type: Form/Rate

Reviewer(s): Rosalind Minor

Authors: Mark Banks, Jana
Peterson, Kathy Foster

Disposition Date: 01/11/2010

Date Submitted: 01/08/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: 12/31/2009

Implementation Date:

State Filing Description:

General Information

Project Name: 790

Status of Filing in Domicile: Authorized

Project Number: 790

Date Approved in Domicile: 11/30/2009

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 01/11/2010

Explanation for Other Group Market Type:

State Status Changed: 01/11/2010

Deemer Date:

Created By: Jana Peterson

Submitted By: Kathy Foster

Corresponding Filing Tracking Number:

Filing Description:

RE:

Limited Health Benefit Policy – 790

Application – A-790 AR

Medical Questionnaire – MQ 790

Outline of Coverage – OLC 790

Medicare Duplication Notice – MDN 790

Actuarial Memorandum and Rates

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Submitted for your review is Equitable Life & Casualty Insurance Company's ("Equitable") new Limited Benefit Health Policy Form 790. This policy is an individual short-term nursing home policy which provides benefits for nursing home stays that are less than 12 months. This policy is a new form and does not replace any form previously filed with the Arkansas Insurance Department ("Department"). The policy is available to individuals ages 50-84 and will be marketed through licensed and appointed independent agents.

Each form in this filing is briefly described as follows:

Policy Form: The policy form is the contract of insurance. Subject to a waiting period, if any, the policy pays the insured a daily amount for each day of the insured's nursing home, up to a maximum benefit period of no more than 350 days. Policy benefits are triggered when an insured shows, on assessment, to be deficient in two or more ADLs, or cognitively impaired.

Insureds may choose at the time of application, a daily amount, maximum benefit period and the waiting period as follows:

- Daily amount from \$50 to \$300 in \$10 increments (daily benefit of no more than \$200 for issue ages 76 and older)
- Maximum benefit period of 100, 150, 200, 250, 300 or 350 days
- Waiting period of 0, 30 or 90 days

The policy is guaranteed renewable and contains a six month pre-existing condition waiting period.

A 10% premium discount is available when two policies are issued to members of the same household, such as a spouse.

Application Form and Medical Questionnaire: The application and medical questionnaire forms are used to gather an applicant's personal information, including, but not limited to, the applicant's name and address, benefit selection, and medical history.

Equitable completes the application and medical questionnaire forms during a point-of-sale telephone interview with both the applicant and agent. When an agent meets with an applicant, he or she will use the medical questionnaire form to pre-qualify the applicant for the policy. The agent will also prepare the applicant to identify premium payment information, and will then contact the Equitable by telephone.

Equitable completes the application and medical questionnaire forms with the applicant, and gathers the agent information required in the application from the agent. The interview will be recorded, including all verbal "signatures", and stored. Upon completion of the application and medical questionnaire, the information is stored electronically for underwriting and policy issuance. A copy of the completed application and medical questionnaire will be attached to the

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 policy when issued.

Outline of Coverage: The outline of coverage provides a brief description of the benefits provided under the policy. The outline of coverage will be provided to all prospective insureds at the time of application.

Medicare Duplication Notice: The Medicare duplication notice will be provided to all prospective insureds that are eligible for Medicare at the time of application.

Replacement Notice: The replacement notice will be used when a prospective insured intends to replace an existing accident and health insurance policy with this policy. The replacement notice will be provided and completed by the prospective insured and his or her agent at the time of application. The replacement notice used with this policy will be our form RN 30, which was approved by the Department on April 9, 2009 (SERFF Tracking # ELCC-125439308, Arkansas Tracking #3875).

Company and Contact

Filing Contact Information

Jana Peterson, Compliance Specialist Jana.Peterson@Equilife.com
 3 Triad Center 877-579-3782 [Phone]
 Suite 200 801-579-3781 [FAX]
 Salt Lake City, UT 84180

Filing Company Information

Equitable Life & Casualty Insurance Company	CoCode: 62952	State of Domicile: Utah
3 Triad Center	Group Code: -99	Company Type: Life and Health
Suite 200	Group Name:	State ID Number:
Salt Lake City, UT 84180	FEIN Number: 87-0129771	
(801) 579-3400 ext. [Phone]		

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:
 Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Equitable Life & Casualty Insurance Company	\$0.00	01/08/2010	

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TOI: H13I Individual Health - Short Term Care Sub-TOI: H13I.002 Nursing Home
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/11/2010	01/11/2010

SERFF Tracking Number: ELCC-126393227 *State:* Arkansas
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Disposition

Disposition Date: 01/11/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Limited Health Benefit Policy Providing Short Term Nursing Home Benefits	Approved-Closed	Yes
Form	Application - Short Term Nursing Home Policy	Approved-Closed	Yes
Form	Initial Medical Question- Agent Use Only	Approved-Closed	Yes
Form	Important Notice to Persons on Medicare	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Rate	Premium Rates	Approved-Closed	Yes
Rate	Actuarial Memorandum	Approved-Closed	No

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Form Schedule

Lead Form Number: 790

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 01/11/2010	790	Policy/Cont ract/Fratern al	Limited Health Benefit Policy Providing Short Term Certificate Nursing Home Benefits	Initial		45.200	790-policy.pdf
Approved-Closed 01/11/2010	A-790 AR	Application/ Enrollment Form	Application - Short Term Nursing Home Policy	Initial			a-790_ar app.pdf
Approved-Closed 01/11/2010	790 MQ	Application/ Enrollment Form	Initial Medical Question- Agent Use Only	Initial			790 MQ.pdf
Approved-Closed 01/11/2010	MDN 790	Other	Important Notice to Persons on Medicare	Initial			MDN 790.pdf
Approved-Closed 01/11/2010	OLC 790	Outline of Coverage	Outline of Coverage Coverage	Initial			OLC-790.pdf

**LIMITED BENEFIT HEALTH POLICY
PROVIDING SHORT STAY NURSING HOME BENEFITS**

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, please review the “Guide to Health Insurance for People with Medicare” that You received from Us. **THIS IS NOT A LONG TERM CARE INSURANCE POLICY.**

This Policy is a legal contract between You, named as the Insured in the Policy Schedule, and Us. We promise to pay the benefits provided in this Policy for covered losses incurred by You while this Policy is in force. All benefits are subject to the definitions, limitations, exclusions and all other provisions of this Policy, including any endorsement which may be attached.

YOUR THIRTY DAY RIGHT TO EXAMINE THIS POLICY: If for any reason You are not satisfied with this Policy, return it to Us or to the agent who sold it to You within thirty (30) days after You receive it. We will refund all premiums paid and consider the Policy to never have been issued.

PRE-EXISTING CONDITION LIMITATION: No benefits are payable for any loss that begins within the first six (6) months after the Effective Date of Your Policy which is caused by a Pre-Existing Condition. A Pre-Existing Condition is a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within six (6) months prior to the Effective Date of Your Policy.

CONSIDERATION: In consideration of Your application and the payment of the initial Premium, this Policy will be in force until the first renewal date shown on Your Policy Schedule. Caution: The issuance of this Policy is based upon Your responses to the questions on Your application. A copy of Your application is attached. If your answers are incorrect or untrue, We may have the right to deny benefits or rescind Your Policy, subject to the Time Limit on Certain Defenses (see page 7). The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact Us at: Equitable Life & Casualty, 3 Triad Center, Salt Lake City, UT 84180-1200, or call us, toll free, at 1-800-352-5150.

RENEWAL CONDITIONS – THIS POLICY IS GUARANTEED RENEWABLE FOR LIFE OR UNTIL THE MAXIMUM BENEFIT PERIOD IS REACHED: This means You have the right to continue this Policy as long as You pay Your premium on time. We cannot change any of the terms of Your Policy on Our own, except that in the future We may increase premiums. We will not change the premium for this Policy during Your first year of coverage. Thereafter, We may change the premium for this Policy, but only if We change it for all policies like Yours in Your state on a premium class basis. A premium class is determined by age, benefits and the year this Policy is issued. You will be notified at least thirty-one (31) days before any premium change.

EFFECTIVE DATE: This Policy, as signed by Our President and Secretary, begins at 12:01 a.m. in the time zone in which You reside on the Effective Date shown in the Policy Schedule. It ends, subject to the Grace Period, at 12:01 a.m. on the date any renewal premium is due and not paid.


Secretary


President

THIS IS A LIMITED POLICY - PLEASE READ IT CAREFULLY

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POLICY SCHEDULE

In this Policy We often refer to Your Policy Schedule. This schedule is important. It tells You the amount of premium and the amount of benefits You have chosen.

Insured:	{John Doe}	Policy Number:	{1234567}
		Effective Date:	{01/01/2010}
Initial Premium:	{\$XXX.XX}	First Renewal Date:	{03/01/2010}
{Alternate Payor:	Bob Doe}	Policy Anniversary Date:	{January 1}

DIRECT BILL RENEWAL PREMIUMS

Annual	Semi-Annual	Quarterly
{\$XXX.XX}	\$XXX.XX	{\$XXX.XX}

BANK DRAFT RENEWAL PREMIUMS

Annual	Semi-Annual	Quarterly	Monthly
{\$XXX.XX}	\$XXX.XX	{\$XXX.XX}	\$\$X.XX}

POLICY BENEFITS

Daily Amount..... {\$50.00 - \$300.00}
Maximum Benefit Period {100} {150} {200} {250} {300} {350} Days
Waiting Period {0} {30} {90} Days

DEFINITIONS

In this Policy the words "You", "Your" and "Yourself" refer to the Insured named in the Policy Schedule. The words "We," "Us," and "Our" refer to Equitable Life & Casualty Insurance Company.

ACTIVITIES OF DAILY LIVING (ADLs): Means, for the purpose of benefit determination:

- a) Bathing – Your ability to wash Yourself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower. It does not include only washing Your hair or back.
- b) Continence – Your ability to maintain control of bowel and bladder function; or when You are unable to maintain control of bowel or bladder function, Your ability to perform associated personal hygiene, including caring for a catheter or a colostomy bag.
- c) Dressing – Your ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.
- d) Eating – Your ability to feed Yourself by getting food into Your body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously. It does not include meal preparation or setup.
- e) Toileting – Your ability to get to and from the toilet, to get on and off the toilet, and to perform associated personal hygiene.
- f) Transferring – Your ability to move into or out of a bed, a chair or a wheelchair. It does not include the task of getting into or out of a tub or shower.

ASSESSMENT: Means a comprehensive, written evaluation done to determine if, or verify that, You are unable to perform two (2) or more ADLs or You are cognitively impaired. The Assessment includes generally accepted tests and instruments that use objective measures and produce verifiable results that will determine if You are eligible for benefits under this Policy.

ASSESSMENT PROVIDER: Means an agency, entity or a person designated and approved by Us that performs Assessments. Assessment Providers are Licensed Health Care Practitioners trained to perform Assessments.

COGNITIVE IMPAIRMENT: Means the deterioration or loss of Your intellectual or mental capacity, as determined by clinical tests and evidence, resulting in Your need for continual assistance or supervision by another person to properly care for yourself.

COMPREHENSIVE MINIMUM DATA SET (MDS) ASSESSMENT: Means the clinical assessment, developed for the U.S. Centers for Medicare & Medicaid Services (CMS), which requires the Full Minimum Data Set (MDS), Resident Assessment Protocols (RAPs) Utilization Guidelines and Care Plan, as defined by CMS, for all residents of Medicare or Medicaid certified Nursing Homes. Comprehensive MDS Assessments include all required MDS items (including State-designated sections), RAPs, and documentation in accordance with the Utilization Guidelines.

HANDS-ON ASSISTANCE: Means the continual physical assistance of another person without which You would be unable to perform any two (2) or more of the Activities of Daily Living (ADLs).

LICENSED HEALTH CARE PRACTITIONER: Means a physician (as defined in Sec. 1861(r)(1) of the Social Security Act), a registered professional nurse or a licensed social worker. A Licensed Health Care Practitioner may not be related to you by blood, adoption or marriage, nor may he or she be the proprietor of a Nursing Home.

MAXIMUM BENEFIT PERIOD: Means the maximum number of days for which We will pay benefits under this Policy. Your Maximum Benefit Period is shown in the Policy Schedule.

MEDICARE: Means the federal program for health care reimbursement established under Title XVIII of The Social Security Act, as amended.

NURSING CARE SERVICES: Means those services which are performed under orders of a doctor for the purpose of meeting either the medical or personal care needs of the person residing in a Nursing Home, and are performed at the direction and under the supervision of a licensed registered or practical nurse.

NURSING HOME: Means a place which is a separate facility or distinct part of a health care facility which is licensed as a nursing home, is operated pursuant to law, provides continuous accommodations to persons who require daily Nursing Care Services, and maintains records of each patient or resident.

A Nursing Home does **NOT** include the following places or facilities:

- a) a hospital;
- b) an assisted living facility;
- c) an adult foster home;
- d) an Alzheimer's care facility or unit;
- e) a residential care facility;
- f) a personal care facility;
- g) a hospice facility;
- h) a sanatorium;
- i) a place primarily providing care for alcoholism or substance abuse;
- j) a place primarily providing care and treatment of mental disease or mental disorders;
- k) a home for the aged, a rest home, a community living center, or a place that primarily provides domiciliary custodial, retirement or educational care;
- l) a continuing care retirement community, an independent living unit, an apartment or Your home; or
- m) any other facility or entity not licensed as a nursing home in Your state of residence.

WAITING PERIOD: Means the number of consecutive days of a stay in a Nursing Home required before benefits are payable. You need to satisfy Your Waiting Period, as shown on Your Policy Schedule, only once during Your lifetime.

ELIGIBILITY FOR BENEFITS

You are eligible for benefits under this Policy when We receive Eligibility Documentation which establishes that:

- a) Your stay in a Nursing Home is reasonable and necessary because You cannot perform, without the Hands-on Assistance of another person, two (2) or more of the Activities of Daily Living (ADL's), or
- b) Your stay in a Nursing Home is reasonable and necessary due to Your Cognitive Impairment.

In addition to Our receipt of the Eligibility Documentation, benefits will be payable only when:

- a) Your stay in a Nursing Home begins while Your Policy is in force; and
- b) You receive Nursing Care Services.

ELIGIBILITY DOCUMENTATION

MDS: If the Nursing Home in which You reside is a Medicare or Medicaid certified Nursing Home or is required by state law to use the Comprehensive MDS Assessment, We must be provided with a completed Comprehensive MDS Assessment verifying Your eligibility for benefits under this Policy. A Comprehensive MDS Assessment will be completed by the Nursing Home staff within the initial fourteen (14) days of Your stay.

ASSESSMENT AT OUR EXPENSE: If the Nursing Home in which You reside is not a Medicare or Medicaid Certified Nursing Home and is not required by state law to use the Comprehensive MDS Assessment, We must be provided with a written Assessment verifying Your eligibility for benefits. We will pay all costs associated with the performance of the Assessment by an Assessment Provider.

ASSESSMENT AT YOUR EXPENSE: At Your option, You may have an Assessment completed prior to Your stay in any Nursing Home. If You choose to receive such an Assessment, You will be responsible for all costs associated with the performance of the Assessment.

POLICY BENEFITS

NURSING HOME BENEFITS: We will pay You the Daily Amount You selected for each day of Your stay in a Nursing Home when You are determined to be eligible for benefits (see Eligibility for Benefits).

We will pay Nursing Home Benefits up to the Maximum Benefit Period. Payment of benefits is subject to the Waiting Period and to all provisions of Your Policy.

The Daily Amount, the Maximum Benefit Period and the Waiting Period are listed on Your Policy Schedule.

BENEFITS DUE TO COGNITIVE IMPAIRMENT: We will pay benefits to You for Nursing Home stays when You are eligible for benefits due to Cognitive Impairment, such as Parkinson's disease, Alzheimer's disease, dementia, or biologically based brain diseases and serious mental illnesses.

ALTERNATE CARE: We may agree to pay benefits for Nursing Care Services provided in facilities not specifically covered in this Policy. These benefits may be payable when they are in lieu of services provided in facilities covered in this Policy that are unavailable to You and are a cost effective alternative appropriate for Your needs. Alternate Care benefits are subject to Your Waiting Period, if any; and Maximum Benefit Period. Our approval of Alternate Care is required before benefits are payable.

LIMITATIONS AND EXCLUSIONS

This Policy does not cover any loss:

- a) Resulting from war or an act of war, whether declared or undeclared;
- b) Occurring outside the territorial limits of the United States or its possessions;
- c) Due to alcohol or drug use, except as ordered by a doctor;
- d) For any stay in a U.S. government facility, where there is no charge to you;
- e) Caused by a self-inflicted injury or attempted suicide, whether You are sane or insane; or
- f) For any stay in an assisted living facility, assisted living residence, or any other facility which is not a Nursing Home as defined herein.

CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice of claim must be given to Us within twenty (20) days after a covered loss begins or as soon as reasonably possible. The notice can be given to Us at Our Home Office or to an authorized agent. The notice should include Your name and Policy number.

CLAIM FORMS: When We receive Your Notice of Claim, We will send You forms for filing Proof of Loss. If these forms are not given to You within fifteen (15) days after giving such notice, You can meet this requirement by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss provision.

PROOFS OF LOSS: Written Proof of Loss must be given to Us within ninety (90) days after the date of loss. If it was not reasonably possible for You to give Us proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than one (1) year from the time specified unless You were legally incapacitated.

TIMELY PAYMENT OF CLAIMS: Benefits payable under this Policy will be paid as soon as We receive proper written Proof of Loss.

PAYMENT OF CLAIMS: All benefits will be paid to You, or Your assignee. Any benefits unpaid at Your death may be paid to Your estate.

ASSIGNMENT: No Assignment of benefits under this Policy shall be binding upon Us unless it is in writing and the original (or a copy of it) is on file with Us. We do not assume any responsibility for the validity of any Assignment. Any payment We make in good faith will end Our liability to the extent of the payment.

UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

EXAMINATIONS AND PERIODIC ASSESSMENTS: We, at Our expense, reserve the right to have You examined and re-assessed to determine Your continued eligibility for the payment of benefits when and as often as reasonably necessary throughout the duration of a claim.

CLAIM REVIEW: If You believe that Our claim decision is in error, You may appeal Our decision and We will reconsider Your claim. Send Us a written request (no special form is required) explaining why, under the provisions of Your Policy, We should change Our decision.

Your written request must be submitted within sixty (60) days of Your receipt of the Explanation of Benefits (EOB) of Your claim. You may authorize someone else to act for You in this process. Your written request should include Your name, the Policy number, the names, addresses and phone numbers of any persons or organizations You believe We should contact to learn more about the claim under reconsideration, and any supporting documentation or records.

Once We have completed Our review, We will notify You in writing of Our decision. This notification will be sent to You no later than thirty (30) days after receipt of Your written request for appeal. We will pay any benefits that may then be due as a result of Our reconsideration. Should We require longer than thirty (30) days to make Our decision, We will notify You of the reasons for this delay. In any event, the delay will be no longer than an additional forty-five (45) days. Our final decision on Your appeal does not prevent You from taking further legal action.

IMPORTANT CONTRACT PROVISIONS

ENTIRE CONTRACT; CHANGES: This Policy, with its endorsements and any attached papers, is the entire contract between You and Us. No change in this Policy will be effective until it is approved by one of Our officers. This approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: No statements, except fraudulent misstatements in Your application for this Policy shall be used to void this Policy or to deny a claim for loss incurred after two (2) years from the Effective Date of this Policy. A copy of Your application is attached.

GRACE PERIOD: This Policy has a thirty-one (31) day Grace Period. This means if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period this Policy will stay in force.

ALTERNATE PAYOR: An Alternate Payor is a person selected by You to receive a reminder of the renewal premium due if You have not paid it during the Grace Period. Your Alternate Payor is shown in the Policy Schedule. This Policy contains a thirty-one (31) day Grace Period plus a fifteen (15) day Conservation Period for the payment of renewal premiums.

CONSERVATION PERIOD: You have an additional fifteen (15) days beyond the Grace Period to pay Your premium. During this fifteen (15) day extension, this Policy is not in force unless Your premium is paid within this period. This Policy will then be renewed with no lapse in coverage.

POLICY TERMINATION: This Policy will terminate and coverage will end on the earliest of:

- a) the date that the Maximum Benefit Period is reached;
- b) the date this Policy lapses for non-payment of premium following the Grace Period; or
- c) the date of Your death.

Termination of this Policy for non-payment of premium is subject to the Extension of Benefits provision.

REINSTATEMENT: If the renewal premium is not paid before the Grace Period ends, this Policy will lapse. Later acceptance of premium by Us (or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate this Policy. If We or Our agent require an application, You will be given a conditional receipt for the premium. If the application is approved, this Policy will be reinstated as of the approval date. Lacking such approval, this Policy will be reinstated on the forty-fifth (45th) day after the date of the conditional receipt unless We have previously notified You, in writing, of Our disapproval.

The reinstated Policy will only cover a loss that results from an injury sustained after the date of reinstatement, or sickness that begins more than ten (10) days after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated Policy. Any premium accepted with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

EXTENDED REINSTATEMENT: If this Policy has lapsed due to the Cognitive Impairment of the Insured, We will reinstate this Policy upon receiving proof of such impairment within six (6) months of the date of lapse. All past due premium must be paid in order to reinstate this Policy.

EXTENSION OF BENEFITS: Termination of coverage shall be without prejudice to any benefits payable for losses covered by this Policy while this Policy is in force and will continue without interruption after termination. Benefits are payable for no longer than the date Your Maximum Benefit Period is reached or the date You are discharged from the Nursing Home, whichever is earlier. Extension of Benefits is subject to all other applicable provisions of this Policy.

REFUND OF PREMIUM AT DEATH: We will refund that part of any premium paid for an insured person which covers a period beyond the end of the Policy month of that person's death.

LEGAL ACTION: No legal action may be brought to recover on this Policy within sixty (60) days after written Proof of Loss has been given as required by this Policy. No action may be brought after three (3) years from the time written Proof of Loss is required to be given.

OTHER INSURANCE WITH US: You can be insured under only one Policy in this Policy form series with Us. If, through error, You are insured under any other Policy in this Policy form series, only the one Policy You choose to keep will be effective. We will refund the premiums paid for any insurance which is not effective.

MISSTATEMENT OF AGE: If Your age at the time Your Policy was issued was misstated, We will pay only such amounts as the premium paid would have purchased at the correct age. In the event an age is overstated, We will refund any premium that may be due when We have been notified of this fact. If based on Your correct age We would not have issued this Policy, Our liability will be limited to the refund of any premium paid, subject to an adjustment for paid claims.

CONFORMITY WITH STATE LAWS: Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the state in which You reside on that date is amended to conform to the minimum requirements of those laws.

Equitable Life & Casualty Insurance Company

3 Triad Center, Salt Lake City, Utah 84180

Application - Short Term Nursing Home Policy

- New Business
- Coverage Change

Part I — Personal Information

Title: Mr. Mrs. Miss Ms. Other _____

Last Name _____ First Name _____ MI _____

Birthdate (mm/dd/yyyy) _____ Social Security Number _____ Age: _____ Height _____ Weight _____ Gender Female Male

Street Address _____ Joint Discount: Yes No

City _____ State _____ Zip _____ Policyowner Discount Name _____

Daytime Phone: (____)____-____-____ Evening Phone: (____)____-____-____

Best Time to Call: _____ E-Mail Address: _____

Will this Policy replace an existing Accident and Health insurance policy? Yes No (If yes, complete a replacement notice)

Company	Type of Policy	Policy Number

DOCTOR LAST SEEN

Dr. Name (Last) _____ First / Middle _____

Street Address _____

City _____ State _____ Zip _____

Part II — Benefits Selection

Daily Amount	Benefit Period	Waiting Periods
\$____ ({\$50} up to {\$300} in \$10 increments)	<input type="checkbox"/> {100 days} <input type="checkbox"/> {150 days} <input type="checkbox"/> {200 days}	<input type="checkbox"/> {0 Day} <input type="checkbox"/> {30 Days} <input type="checkbox"/> {90 Days}
	<input type="checkbox"/> {250 days} <input type="checkbox"/> {300 day} <input type="checkbox"/> {350 days}	

Part III — Alternate Payor

I understand that an Alternate Payor is a person other than myself who will receive notice of lapse or termination of my insurance policy for nonpayment of premium. My Alternate Payor will not be notified until thirty (30) days after a premium is due and unpaid.

Alternate Payor – (First Name - MI - Last Name) _____

Address _____

City _____ State _____ Zip _____

Agent Supplement

Yes No

All questions must be completed.

- 1. Did you personally interview the applicant?
- 2. State the name and relationship of any other person present when this application was taken.
Name _____ Relationship _____
- 3. Did you review the application for correctness and any omissions?
- 4. Did the applicant review the application for correctness and any omissions?

Agent #1 Signature _____ Date _____

Agent #2 Signature _____ Date _____

Agent #1 Name (please print) _____ Agent # _____ Split % _____

Agent #2 Name (please print) _____ Agent # _____ Split % _____

A-790 AR

Page 3

Agent Checklist

The following Checklist is intended as a helpful reminder to you of the Forms to be submitted with an Application. Applications submitted without ALL required Forms delay the underwriting process until the Forms are submitted. *Forms to be submitted to the Home Office are marked "Return to Company" and have a bar code in the middle bottom area. All forms to be left with the Applicant are marked "Leave with Applicant" in the middle bottom.*

Forms for the Home Office

- Application (A-790)** — All Sections must be completed
- Health Information Authorization (HHA-04)** — for the release of health information
- Replacement Notice (RN-30)** — complete both Notices

Forms for the Applicant

- Health Information Authorization(HHA-04)
- Outline of Coverage (OLC 790)
- MDN-790
- Replacement Notice (if needed) (RN-30)
- Receipt

Other Items to Remember

Applicants age 65 or older receive the **Guide to Health Insurance for People with Medicare**. *Additional Forms can be ordered by calling 1-800-352-5125 or by visiting our exclusive producers web-site: www.EquiLine.com.*

Initial Medical Questions - Agent Use ONLY

Please check "Yes" or "No" beside each question. If the answer to any question is "Yes", a policy cannot be issued.

Yes No

- | | | |
|--|--------------------------|--------------------------|
| 1. Do you require supervision or assistance with activities of daily living such as walking, eating, bathing, dressing, toileting, moving into or out of a bed or chair or with taking medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you use a walker, wheelchair, quad cane, motorized personal transport, chair lift or oxygen? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had an organ transplant (other than corneal) or a defibrillator implanted? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. In the past 12 months, have you been confined in a hospital or had heart surgery including bypass, angioplasty, stent placement or heart valve surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. In the past two years: | | |
| a. Has a medical professional scheduled or advised you to have surgery requiring general anesthesia, or undergo testing and you have not done so? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have you resided or been advised to reside in a Nursing Home or Assisted Living Facility? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Have you received or been medically advised to receive Home Health Care or Adult Day Care services? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have you had a balance disorder or difficulty walking? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. In the past two years, have you had, been diagnosed, received treatment or taken medication for any of the following conditions? | | |
| a. Alzheimer's disease, dementia or memory loss | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Acquired Immune Deficiency Syndrome (AIDS) or HIV positive | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Amyotrophic Lateral Sclerosis (ALS), Multiple Sclerosis, Muscular Dystrophy, Parkinson's disease or myasthenia gravis | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Psychosis or Schizophrenia | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Diabetes with complications such as retinopathy (eye disease) neuropathy (numbness/tingling in hands or feet) or kidney failure | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Internal cancer, leukemia, lymphoma or melanoma | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Osteoporosis with related fracture(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Systemic lupus, kidney failure, cirrhosis of the liver or hydrocephalus | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Stroke or cerebrovascular accident (CVA), TIA, congestive heart failure or atrial fibrillation | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Amputation due to disease | <input type="checkbox"/> | <input type="checkbox"/> |



3 Triad Center
Salt Lake City, Utah 84180

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before you Buy This Insurance

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

**OUTLINE OF COVERAGE
LIMITED BENEFIT HEALTH COVERAGE
SHORT STAY NURSING HOME BENEFITS
Policy Form 790**

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from the company. **THIS IS NOT A LONG TERM CARE INSURANCE POLICY.**

(1) PLEASE READ YOUR POLICY CAREFULLY: This Outline of Coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

(2) LIMITED BENEFIT HEALTH COVERAGE: Limited Benefit Health Coverage is designed to provide, to persons insured, limited or supplemental coverage. The policy benefits are outlined in Section 3 below; the benefits described in Section 3 may be limited by the limitations contained in Section 5.

(3) BENEFITS PROVIDED UNDER THE POLICY:
NURSING HOME BENEFITS: We will pay you the Daily Amount you selected for each day of your stay in a Nursing Home when you are determined to be eligible for benefits (see Eligibility for Benefits).

We will pay Nursing Home Benefits up to the Maximum Benefit Period. Payment of benefits is subject to the Waiting Period and to all provisions of the policy. This benefit is subject to the Waiting Period and the Maximum Benefit Period.

BENEFITS DUE TO COGNITIVE IMPAIRMENT: We will pay benefits to you for Nursing Home stays when you are eligible for benefits due to Cognitive Impairment, such as Parkinson's disease, Alzheimer's disease, dementia, or biologically based brain diseases and serious mental illnesses.

ALTERNATE CARE: We may agree to pay benefits for Nursing Care Services provided in facilities not specifically covered in the policy. These benefits may be payable when they are in lieu of services provided in facilities covered in the policy that are unavailable to you and are a cost effective alternative appropriate for your needs. Alternate Care benefits are subject to your Waiting Period, if any; and Maximum Benefit Period. Our approval of Alternate Care is required before benefits are payable.

ELIGIBILITY FOR BENEFITS: You are eligible for benefits under the policy when we receive Eligibility Documentation which establishes that:

- a) Your stay in a Nursing Home is reasonable and necessary because you cannot perform, without the Hands-on Assistance of another person, two (2) or more of the Activities of Daily Living (ADL's), or
- b) Your stay in a Nursing Home is reasonable and necessary due to your Cognitive Impairment.

In addition to our receipt of the Eligibility Documentation, benefits will be payable only when:

- a) Your stay in a Nursing Home begins while the policy is in force; and
- b) You receive Nursing Care Services.

ELIGIBILITY DOCUMENTATION:
MDS: If the Nursing Home in which you reside is a Medicare or Medicaid certified Nursing Home or is required by state law to use the Comprehensive MDS Assessment, we must be provided with a completed Comprehensive MDS Assessment verifying your eligibility for benefits under the policy. A Comprehensive MDS Assessment will be completed by the Nursing Home staff within the initial fourteen (14) days of your stay.

ASSESSMENT AT OUR EXPENSE: If the Nursing Home in which you reside is not a Medicare or Medicaid Certified Nursing Home and is not required by state law to use the Comprehensive MDS Assessment, we must be provided with a written Assessment verifying your eligibility for benefits. We will pay all costs associ-

Outline of Coverage

ated with the performance of the Assessment by an Assessment Provider.

ASSESSMENT AT YOUR EXPENSE: At your option, you may have an Assessment completed prior to your stay in any Nursing Home. If you choose to receive such an Assessment, you will be responsible for all costs associated with the performance of the Assessment.

BENEFIT LEVELS:

The daily amounts, maximum benefit periods and waiting periods available with the policy are as follows:

Daily Amounts: You may select a daily amount from {\$50 to \$300} in \$10 increments.

Maximum Benefit Periods: You may select a maximum benefit period of {100}, {150}, {200}, {250}, {300} or {350} days.

Waiting Periods: You may select a waiting period of {0}, {30} or {90} days.

(4) IMPORTANT DEFINITIONS:

ACTIVITIES OF DAILY LIVING (ADLs): Means, for the purpose of benefit determination:

- a) Bathing – Your ability to wash yourself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower. It does not include only washing your hair or back.
- b) Continence – Your ability to maintain control of bowel and bladder function; or when you are unable to maintain control of bowel or bladder function, your ability to perform associated personal hygiene, including caring for a catheter or a colostomy bag.
- c) Dressing – Your ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.
- d) Eating – Your ability to feed yourself by getting food into your body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously. It does not include meal preparation or setup.
- e) Toileting – Your ability to get to and from the toilet, to get on and off the toilet, and to perform associated personal hygiene.

- f) Transferring – Your ability to move into or out of a bed, a chair or a wheelchair. It does not include the task of getting into or out of a tub or shower.

ASSESSMENT: Means a comprehensive, written evaluation done to determine if, or verify that, you are unable to perform two (2) or more ADLs or you are cognitively impaired. The Assessment includes generally accepted tests and instruments that use objective measures and produce verifiable results that will determine if you are eligible for benefits under the policy.

ASSESSMENT PROVIDER: Means an agency, entity or a person designated and approved by Us that performs Assessments. Assessment Providers are Licensed Health Care Practitioners trained to perform Assessments.

COGNITIVE IMPAIRMENT: Means the deterioration or loss of your intellectual or mental capacity, as determined by clinical tests and evidence, resulting in your need for continual assistance or supervision by another person to properly care for yourself.

COMPREHENSIVE MINIMUM DATA SET (MDS) ASSESSMENT: Means the clinical assessment, developed for the U.S. Centers for Medicare & Medicaid Services (CMS), which requires the Full Minimum Data Set (MDS), Resident Assessment Protocols (RAPs) Utilization Guidelines and Care Plan, as defined by CMS, for all residents of Medicare or Medicaid certified Nursing Homes. Comprehensive MDS Assessments include all required MDS items (including State-designated sections), RAPs, and documentation in accordance with the Utilization Guidelines.

LICENSED HEALTH CARE PRACTITIONER: Means a physician (as defined in Sec. 1861(r)(1) of the Social Security Act), a registered professional nurse or a licensed social worker. A Licensed Health Care Practitioner may not be related to you by blood, adoption or marriage, nor may he or she be the proprietor of a Nursing Home.

Outline of Coverage

MAXIMUM BENEFIT PERIOD: Means the maximum number of days for which we will pay benefits under the policy. Your Maximum Benefit Period is shown in the policy schedule.

MEDICARE: Means the federal program for health care reimbursement established under Title XVIII of The Social Security Act, as amended.

NURSING CARE SERVICES: Means those services which are performed under orders of a doctor for the purpose of meeting either the medical or personal care needs of the person residing in a Nursing Home, and are performed at the direction and under the supervision of a licensed registered or practical nurse.

NURSING HOME: Means a place which is a separate facility or distinct part of a health care facility which is licensed as a nursing home, is operated pursuant to law, provides continuous accommodations to persons who require daily Nursing Care Services, and maintains records of each patient or resident.

A Nursing Home does NOT include the following places or facilities:

- a) a hospital;
- b) an assisted living facility;
- c) an adult foster home;
- d) an Alzheimer's care facility or unit;
- e) a residential care facility;
- f) a personal care facility;
- g) a hospice facility;
- h) a sanatorium;
- i) a place primarily providing care for alcoholism or substance abuse;
- j) a place primarily providing care and treatment of mental disease or mental disorders;
- k) a home for the aged, a rest home, a community living center, or a place that primarily provides domiciliary custodial, retirement or educational care;
- l) a continuing care retirement community, an independent living unit, an apartment or your home; or
- m) any other facility or entity not licensed as a nursing home in your state of residence.

WAITING PERIOD: Means the number of consecutive days of a stay in a Nursing Home required before benefits are payable. You need to satisfy your waiting period, as shown on your policy schedule, only once during your lifetime.

(5) LIMITATIONS AND EXCLUSIONS:

The policy does not cover any loss:

- a) Resulting from war or an act of war, whether declared or undeclared;
- b) Occurring outside the territorial limits of the United States or its possessions;
- c) Due to alcohol or drug use, except as ordered by a doctor;
- d) For any stay in a U.S. government facility, where there is no charge to you;
- e) Caused by a self-inflicted injury or attempted suicide, whether you are sane or insane; or
- f) For any stay in an assisted living facility, assisted living residence, or any other facility which is not a Nursing Home as defined in the policy.

(6) GUARANTEED RENEWABILITY OF THE POLICY: You have the right to continue your policy as long as you pay your premiums when due.

(7) PREMIUM: Total annual premium for your policy is _____. We will not change the premium for your policy during your first year of coverage. Thereafter, we reserve the right to change premium rates for all policies of the same class. We will notify you at least 31 days before any premium change.

THIS OUTLINE OF COVERAGE IS A BRIEF SUMMARY OF THE BENEFITS PROVIDED.

PLEASE CONSULT THE POLICY TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS. PLEASE RETAIN THIS OUTLINE OF COVERAGE FOR YOUR RECORDS.

SERFF Tracking Number: ELCC-126393227 State: Arkansas
 Filing Company: Equitable Life & Casualty Insurance Company State Tracking Number: 44518
 Company Tracking Number: 790
 TOI: H13I Individual Health - Short Term Care Sub-TOI: H13I.002 Nursing Home
 Product Name: EquiCare 790
 Project Name/Number: 790/790

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 01/11/2010	Premium Rates		New		Premiums 790 Product 55%.pdf

Premiums for 790 Product

Premiums for 790 Product

Premiums for 790 Product

Premiums per \$10 in Benefits
0 day Elimination Period

Premiums per \$10 in Benefits
30 day Elimination Period

Premiums per \$10 in Benefits
90 day Elimination Period

Age	BP in Days					
	100	150	200	250	300	350
50	13.60	16.40	18.40	21.80	23.60	25.80
51	14.20	17.20	19.40	23.10	25.10	27.50
52	14.80	18.10	20.50	24.60	26.80	29.40
53	15.50	19.10	21.70	26.10	28.60	31.40
54	16.20	20.10	23.00	27.80	30.40	33.50
55	17.00	21.20	24.30	29.50	32.30	35.70
56	17.60	22.00	25.30	30.80	33.80	37.40
57	18.20	22.90	26.40	32.20	35.40	39.20
58	18.80	23.70	27.50	33.60	37.00	41.00
59	19.40	24.60	28.50	35.00	38.60	42.80
60	20.70	26.50	30.90	38.20	42.10	46.90
61	21.40	27.60	32.20	39.90	44.00	49.00
62	22.20	28.70	33.60	41.70	46.10	51.30
63	23.00	29.90	35.10	43.60	48.30	53.80
64	23.90	31.20	36.70	45.70	50.60	56.50
65	24.90	32.70	38.40	48.00	53.20	59.40
66	26.00	34.30	40.40	50.60	56.10	62.70
67	27.30	36.10	42.60	53.40	59.30	66.30
68	28.60	38.00	45.00	56.60	62.90	70.30
69	30.20	40.30	47.80	60.10	66.90	74.90
70	33.30	44.60	52.90	67.00	75.00	83.30
71	35.40	47.60	56.70	71.90	80.50	89.40
72	38.00	51.00	60.50	77.00	87.00	96.60
73	42.00	57.30	68.60	87.30	97.30	109.50
74	46.90	64.00	76.70	97.50	108.80	122.40
75	51.90	70.80	84.80	107.80	120.20	135.20
76	56.80	77.50	92.80	118.10	131.70	148.10
77	61.70	84.20	100.90	128.40	143.10	161.00
78	67.70	93.30	112.20	143.00	159.00	180.40
79	73.20	101.10	121.80	155.40	172.80	196.10
80	79.30	109.90	132.40	169.20	188.70	213.60
81	85.70	119.00	143.50	183.60	204.70	231.90
82	92.70	129.00	155.70	199.40	222.40	252.00
83	100.60	140.20	169.30	217.00	242.10	274.40
84	109.00	152.20	184.00	235.90	263.30	298.50

Age	BP in Days					
	100	150	200	250	300	350
50	12.70	15.40	17.20	20.40	22.10	24.10
51	13.30	16.10	18.10	21.60	23.50	25.70
52	13.80	16.90	19.20	23.00	25.10	27.50
53	14.50	17.80	20.30	24.40	26.70	29.30
54	15.10	18.80	21.50	26.00	28.40	31.30
55	15.90	19.80	22.70	27.50	30.20	33.30
56	16.40	20.50	23.60	28.70	31.50	34.90
57	17.00	21.40	24.60	30.00	33.00	36.60
58	17.50	22.10	25.60	31.30	34.50	38.20
59	18.10	22.90	26.50	32.60	36.00	39.90
60	19.30	24.70	28.80	35.60	39.20	43.70
61	19.90	25.70	30.00	37.10	40.90	45.60
62	20.60	26.70	31.20	38.80	42.90	47.70
63	21.40	27.80	32.60	40.50	44.90	50.00
64	22.20	29.00	34.10	42.50	47.00	52.50
65	23.10	30.40	35.70	44.60	49.40	55.20
66	24.10	31.80	37.50	47.00	52.10	58.20
67	25.30	33.50	39.50	49.50	55.00	61.50
68	26.50	35.20	41.70	52.50	58.30	65.20
69	28.00	37.30	44.30	55.70	62.00	69.40
70	30.80	41.30	49.00	62.00	69.50	77.10
71	32.80	44.10	52.50	66.50	74.50	82.70
72	35.10	47.20	56.00	71.20	80.50	89.40
73	38.80	52.90	63.40	80.70	89.90	101.20
74	43.30	59.10	70.80	90.00	100.40	113.00
75	47.90	65.30	78.20	99.40	110.80	124.70
76	52.30	71.40	85.50	108.80	121.30	136.40
77	56.80	77.50	92.80	118.10	131.70	148.10
78	62.20	85.70	103.10	131.40	146.10	165.80
79	67.20	92.80	111.80	142.70	158.60	180.00
80	72.70	100.80	121.40	155.20	173.00	195.90
81	78.50	109.00	131.40	168.20	187.50	212.40
82	84.80	118.00	142.50	182.50	203.50	230.60
83	91.90	128.10	154.70	198.30	221.30	250.80
84	99.50	139.00	168.00	215.40	240.40	272.50

Age	BP in Days					
	100	150	200	250	300	350
50	11.20	13.50	15.20	18.00	19.40	21.30
51	11.70	14.10	15.90	19.00	20.60	22.60
52	12.10	14.80	16.80	20.20	22.00	24.10
53	12.70	15.60	17.80	21.30	23.40	25.70
54	13.20	16.40	18.80	22.70	24.80	27.30
55	13.80	17.30	19.80	24.00	26.30	29.10
56	14.30	17.90	20.50	25.00	27.40	30.40
57	14.70	18.50	21.40	26.10	28.70	31.80
58	15.20	19.10	22.20	27.10	29.90	33.10
59	15.60	19.80	23.00	28.20	31.10	34.50
60	16.60	21.30	24.80	30.70	33.80	37.70
61	17.20	22.10	25.80	32.00	35.30	39.30
62	17.80	23.00	26.90	33.40	36.90	41.00
63	18.40	23.90	28.00	34.80	38.50	42.90
64	19.00	24.80	29.20	36.40	40.30	45.00
65	19.80	26.00	30.50	38.10	42.20	47.20
66	20.60	27.20	32.00	40.10	44.40	49.70
67	21.60	28.50	33.70	42.20	46.80	52.40
68	22.50	29.90	35.50	44.60	49.60	55.40
69	23.70	31.70	37.60	47.20	52.60	58.90
70	26.10	35.00	41.50	52.50	58.80	65.30
71	27.70	37.20	44.30	56.20	63.00	69.90
72	29.60	39.80	47.20	60.10	67.90	75.30
73	32.60	44.50	53.30	67.80	75.60	85.10
74	36.30	49.50	59.40	75.50	84.20	94.70
75	40.00	54.60	65.40	83.10	92.70	104.20
76	43.60	59.50	71.30	90.70	101.10	113.70
77	47.20	64.40	77.20	98.20	109.50	123.20
78	51.60	71.10	85.50	109.00	121.20	137.50
79	55.60	76.70	92.40	117.90	131.20	148.80
80	60.00	83.10	100.10	127.90	142.70	161.50
81	64.50	89.60	108.10	138.30	154.10	174.60
82	69.50	96.80	116.80	149.60	166.80	189.00
83	75.10	104.70	126.50	162.10	180.80	205.00
84	81.10	113.20	136.90	175.50	195.90	222.10

SERFF Tracking Number: ELCC-126393227 State: Arkansas
 Filing Company: Equitable Life & Casualty Insurance Company State Tracking Number: 44518
 Company Tracking Number: 790
 TOI: H131 Individual Health - Short Term Care Sub-TOI: H131.002 Nursing Home
 Product Name: EquiCare 790
 Project Name/Number: 790/790

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: AR Flesch Certification.pdf	Approved-Closed	01/11/2010

	Item Status:	Status Date:
Satisfied - Item: Application Comments: See Form Schedule Tab	Approved-Closed	01/11/2010

	Item Status:	Status Date:
Satisfied - Item: Health - Actuarial Justification Comments: See Actuarial Memorandum on Rate/Rule Schedule Tab	Approved-Closed	01/11/2010

	Item Status:	Status Date:
Satisfied - Item: Outline of Coverage Comments: See Form Schedule Tab	Approved-Closed	01/11/2010



Ambassadors Of Caring

CERTIFICATION

RE: EquiCare, Limited Health Benefit Insurance Policy, Form 790

This is to certify that the attached policy Form 790 has achieved a Flesch Reading Ease Score of 45.2 and complies with the requirements of Arkansas Stat. Ann. 66-3251 through 6-3258 cited as the Life and Disability Insurance Policy Language Simplification Act.

Dated this January 8, 2010

EQUITABLE LIFE & CASUALTY INSURANCE COMPANY

By

Kendall R. Surfass

Vice President, General Counsel, Corporate Secretary and Vice Chairman