

State: Arkansas **Filing Company:** Equitable Life & Casualty Insurance Company
TOI/Sub-TOI: H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity
Product Name: Hospital Indemnity
Project Name/Number: ELCHIP/ELCHIP

Filing at a Glance

Company: Equitable Life & Casualty Insurance Company
Product Name: Hospital Indemnity
State: Arkansas
TOI: H14I Individual Health - Hospital Indemnity
Sub-TOI: H14I.000 Health - Hospital Indemnity
Filing Type: Form/Rate
Date Submitted: 08/22/2012
SERFF Tr Num: ELCC-128646904
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: ELCHIP

Implementation: On Approval
Date Requested:
Author(s): Mark Banks, Kathy Foster, John Neville, Jennifer Wilson
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 09/25/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** Equitable Life & Casualty Insurance Company
TOI/Sub-TOI: H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity
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General Information

Project Name: ELCHIP Status of Filing in Domicile: Pending
Project Number: ELCHIP Date Approved in Domicile:
Requested Filing Mode: Domicile Status Comments:
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type:
Overall Rate Impact: Filing Status Changed: 09/25/2012
State Status Changed: 09/25/2012
Deemer Date: Created By: Kathy Foster
Submitted By: Mark Banks Corresponding Filing Tracking Number:

Filing Description:

Limited Health Benefit Policy – ELCHIP
Application – ELCHIAP AR
Outline of Coverage – ELCHIOC
Medicare Duplication Notice – MDN-10A
Replacement Notice – ELCHIRN
Actuarial Memorandum and Rates

Submitted for your review is Equitable Life & Casualty Insurance Company's new Hospital Confinement Indemnity Insurance Policy (Form ELCHIP). This policy is a new form and does not replace any form previously filed with the Arkansas Insurance Department.

Policy Form ELCHIP is an individual policy that provides a wide range of benefits for hospital confinement, surgical procedures, emergency room visits, physician office visits and preventive care benefits. The policy is available to individuals ages 40-85 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. The policy provides fixed benefit amounts for hospitalization, ambulance services, emergency room services and related physician visits. Insureds may choose, at the time of application, the benefit amounts and benefit periods from three benefit groupings, or levels, as follows:

Daily Hospital Indemnity Benefit - Maximum 5 days per calendar year

Plan A - \$100 Per Day
Plan B - \$125 Per Day
Plan C - \$250 Per Day

Ambulance Benefit - Maximum 3 trips per calendar year

Plan A - \$75 Per Trip
Plan B - \$100 Per Trip
Plan C - \$125 Per Trip

Emergency Room Benefit - Maximum benefit payable up to 4 times per calendar year

Plan A - \$25 Per Admission

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Plan B - \$25 Per Admission
Plan C - \$50 Per Admission

Hospital Inpatient or ASC Surgical Benefit

Plan A - 10% of Scheduled Benefit Amount, Maximum \$500 per calendar year
Plan B - 10% of Scheduled Benefit Amount, Maximum \$1000 per calendar year
Plan C - 10% of Scheduled Benefit Amount, Maximum \$2500 per calendar year

Hospital Outpatient or ASC Laboratory, and Radiology Services Benefit

Plan A - \$20 per outpatient visit, Maximum of \$500 per calendar year
Plan B - \$25 per outpatient visit, Maximum of \$700 per calendar year
Plan C - \$30 per outpatient visit, Maximum of \$900 per calendar year

Primary Care Physician Office Visit Benefit

Plan A - \$15 per visit, maximum 4 visits per calendar year
Plan B - \$20 per visit, maximum 6 visits per calendar year
Plan C - \$25 per visit, maximum 8 visits per calendar year

Skilled Nursing Benefit - Maximum 20 days per calendar year

Plan A - \$20 per day
Plan B - \$25 per day
Plan C - \$60 per day

Welcome to Medicare Benefit

Plan A - \$25 for initial Medicare preventive physical exam
Plan B - \$25 for initial Medicare preventive physical exam
Plan C - \$25 for initial Medicare preventive physical exam

Annual Medicare Wellness Benefit - Maximum 1 benefit per calendar year

Plan A - \$25 for One Annual Medicare wellness visit
Plan B - \$25 for One Annual Medicare wellness visit
Plan C - \$25 for One Annual Medicare wellness visit

Additional Preventative Care Benefits - Limited to 5 preventative screenings per calendar year

Plan A - \$10 annually for each completed Medicare Covered Preventative Service
Plan B - \$10 annually for each completed Medicare Covered Preventative Service
Plan C - \$10 annually for each completed Medicare Covered Preventative Service

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

Application Form: The application is used to gather an applicant's personal information, including, but not limited to, the applicant's name, address and medical history. Underwriting will be conducted on all applicants through a simplified underwriting procedure by review of the application.

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.

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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.

Company and Contact

Filing Contact Information

Kathy Foster, Regulatory Compliance Analyst
 Equitable Life & Casualty Insurance Company
 3 Triad Center Suite 200
 Salt Lake City, UT 84180
 Kathy.Foster@Equilife.com
 801-579-3468 [Phone]
 801-579-3471 [FAX]

Filing Company Information

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

Filing Fees

Fee Required? Yes
 Fee Amount: \$300.00
 Retaliatory? Yes
 Fee Explanation: Domicile state does not charge filing fees.
 5 Forms x \$50 = \$250
 1 Rate x \$50 = \$50
 Per Company: No

Company	Amount	Date Processed	Transaction #
Equitable Life & Casualty Insurance Company	\$300.00	08/22/2012	61926090

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/25/2012	09/25/2012
Approved-Closed	Rosalind Minor	09/11/2012	09/11/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	09/07/2012	09/07/2012

Response Letters

Responded By	Created On	Date Submitted
Mark Banks	09/10/2012	09/10/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Outline of Coverage	Jennifer Wilson	09/25/2012	09/25/2012
Form	Application	Jennifer Wilson	09/25/2012	09/25/2012

State: Arkansas **Filing Company:** Equitable Life & Casualty Insurance Company
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Disposition

Disposition Date: 09/25/2012

Implementation Date:

Status: Approved-Closed

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Equitable Life & Casualty Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

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 (revised)	Policy	Approved-Closed	Yes
Form	Policy	Replaced	Yes
Form (revised)	Outline of Coverage	Approved-Closed	Yes
Form	Outline of Coverage	Replaced	Yes
Form (revised)	Application	Approved-Closed	Yes
Form	Application	Replaced	Yes
Form	Medicare Duplication Notice	Approved-Closed	Yes
Form	Replacement Notice	Approved-Closed	Yes
Rate	Premium Rates	Approved-Closed	Yes

State: Arkansas **Filing Company:** Equitable Life & Casualty Insurance Company
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Product Name: Hospital Indemnity
Project Name/Number: ELCHIP/ELCHIP

Disposition

Disposition Date: 09/11/2012

Implementation Date:

Status: Approved-Closed

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Equitable Life & Casualty Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

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 (revised)	Policy	Approved-Closed	Yes
Form	Policy	Replaced	Yes
Form (revised)	Outline of Coverage	Approved-Closed	Yes
Form	Outline of Coverage	Replaced	Yes
Form (revised)	Application	Approved-Closed	Yes
Form	Application	Replaced	Yes
Form	Medicare Duplication Notice	Approved-Closed	Yes
Form	Replacement Notice	Approved-Closed	Yes
Rate	Premium Rates	Approved-Closed	Yes

State: Arkansas Filing Company: Equitable Life & Casualty Insurance Company
 TOI/Sub-TOI: H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity
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Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/07/2012
Submitted Date	09/07/2012
Respond By Date	

Dear Kathy Foster,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- Policy, ELCHIP (Form)

Comments:

There needs to be a provision for the refund of unearned premium in the event of death of the insured. Refer to ACA 23-85-134.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking #:

ELCC-128646904

State Tracking #:

Company Tracking #:

ELCHIP

State:

Arkansas

Filing Company:

Equitable Life & Casualty Insurance Company

TOI/Sub-TOI:

H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity

Product Name:

Hospital Indemnity

Project Name/Number:

ELCHIP/ELCHIP

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	09/10/2012
Submitted Date	09/10/2012

Dear Rosalind Minor,

Introduction:

Hi Rosalind,

I have reviewed your letter to this filing. In response:

Response 1

Comments:

A refund of premium at death provision has been added to page 9 of the policy.

Related Objection 1

Applies To:

- Policy, ELCHIP (Form)

Comments:

There needs to be a provision for the refund of unearned premium in the event of death of the insured. Refer to ACA 23-85-134.

Changed Items:

No Supporting Documents changed.

SERFF Tracking #:

ELCC-128646904

State Tracking #:

Company Tracking #:

ELCHIP

State: Arkansas

Filing Company:

Equitable Life & Casualty Insurance Company

TOI/Sub-TOI: H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity

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Form Schedule Item Changes

Item No.	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments	Submitted
1	ELCHIP	POL	Policy	Initial	42.600	ELCHIP.pdf	Date Submitted: 09/10/2012 By: Mark Banks
<i>Previous Version</i>							
1	ELCHIP	POL	Policy	Initial	42.600	ELCHIP.pdf	Date Submitted: 09/10/2012 By: Mark Banks

No Rate/Rule Schedule items changed.

Conclusion:

Please let me know if you have any questions or concerns.

Thanks,

Mark

Sincerely,

Mark Banks

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Product Name: Hospital Indemnity
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Amendment Letter

Submitted Date: 09/25/2012

Comments:

When reviewing this filing, it was noted that the marketing name on the forms (Hospital Advantage Plus) was incorrect. We have now removed the marketing name from the application and outline of coverage.

In addition, two other changes were made to the application:

“Pharmacy benefit manager” has been added to the list of entities from whom we may obtain information.

A “Re-disclosure Statement” has been added.

The correct forms have now been submitted under the Forms Schedule tab.

We apologize for the error.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
ELCHIOC	Outline of Coverage	Outline of Coverage	Initial					ELCHIOC.pdf
ELCHIAP AR	Application/Enrollment Form	Application	Initial					ELCHIAP AR.pdf

State: Arkansas

Filing Company:

Equitable Life & Casualty Insurance Company

TOI/Sub-TOI: H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity

Product Name: Hospital Indemnity

Project Name/Number: ELCHIP/ELCHIP

Form Schedule

Lead Form Number: ELCHIP

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 09/11/2012	ELCHIP	POL	Policy	Initial:	42.600	ELCHIP.pdf
2	Approved-Closed 09/25/2012	ELCHIOC	OUT	Outline of Coverage	Initial:		ELCHIOC.pdf
3	Approved-Closed 09/25/2012	ELCHIAP AR	AEF	Application	Initial:		ELCHIAP AR.pdf
4	Approved-Closed 09/11/2012	MDN-10A	OTH	Medicare Duplication Notice	Initial:		MDN-10A.pdf
5	Approved-Closed 09/11/2012	ELCHIRN	OTH	Replacement Notice	Initial:		ELCHIRN.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

POLICY

for Hospital Confinement Indemnity Insurance

EQUITABLE LIFE & CASUALTY INSURANCE COMPANY

[Hospital Advantage Plus Administrative Office: P.O. Box 16958, Clearwater FL, 33766-6958]

[(855) 755-4663]

EFFECTIVE DATE: Your insurance under this Individual Policy (hereinafter referred to as the "Policy") begins at 12:01 a.m. at your residence on the Effective Date shown in the Policy Schedule.

Signed for Equitable Life & Casualty Insurance Company at Salt Lake City, Utah by:


Secretary


President

The Policy has been issued and delivered to You, named as the Insured in the Policy Schedule.

This Policy establishes that You are covered by the described insurance, subject to the terms and conditions of this Policy. Your coverage under this Policy will be renewable for Your lifetime, subject to the timely payment of the renewal premiums as they are due.

This Policy describes the benefits, important provisions, exceptions and limitations of this Policy. Insurance under this Policy is effective only if You remain Insured.

This Policy pays benefits in addition to any other health insurance You may have, including Medicare.

This Policy is NOT MEDICARE SUPPLEMENT insurance. If You are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from Us.

POLICY RENEWAL CONDITIONS – YOUR POLICY IS GUARANTEED RENEWABLE: This means You have the right to continue Your 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 may change the renewal Premium for Your Policy, but only if We change them for all policies like Yours in Your state on a Premium class basis. A Premium class is determined by factors including, but not limited to, age and the year the Policy is issued. You will be notified at least thirty-one (31) days before any Premium change. Your Premium will not increase due to a change in Your individual age or Your specific health.

ABOUT STATEMENTS MADE IN YOUR APPLICATION

Caution: This Policy was issued based upon Your answers 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. 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 within 30 days at Our Administrative Office, [P.O. Box 16958, Clearwater, FL 33766-6958]. If You have any questions concerning this coverage, or if We can be of any assistance, please call Us at [1-855-775-4663].

30-DAY RIGHT TO EXAMINE COVERAGE: You may cancel coverage under this Policy within thirty (30) days of receiving it by returning the Policy to Us or to the agent of record. If it is returned for cancellation, We will refund any premium paid for Your coverage, minus any paid claims. This Policy will then be void as of the Effective Date and there will be no coverage.

NOTICE TO BUYER: This Policy may not cover all of the costs associated with Hospital Confinement incurred by You during the period of coverage. You are advised to review carefully all Policy limitations and exceptions.

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POLICY SCHEDULE

Insured Name	Policy Number		Insured's Age at Date of Issue
Street Address	City	State	Zip
Initial Premium Amount \$	Premium Mode	Policy Effective Date	

	Policy Benefits	Maximum Per Calendar Year
Daily Hospital Indemnity Benefit	[\$100,\$125,\$250] Per Day	5 Days
Ambulance Benefit	[\$75,\$100,\$125] Per Trip	3 Trips
Emergency Room Benefit	[\$25,\$50] Per Admission	4 Admissions
Hospital Inpatient or ASC Surgical Benefit	10% of Medicare Fee Schedule Amount	[\$500,\$1,000,\$2,500]
Hospital Outpatient or ASC Laboratory & Radiology Benefit	[\$20,\$25,\$30] Per Outpatient Visit	[\$500,\$700,\$900]
Primary Care Physician Office Visit Benefit	[\$15,\$20,\$25] Per Visit	[4,6,8] Visits
Skilled Nursing Benefit	[\$20,\$25,\$60] Per Day	20 Days
Welcome to Medicare Benefit	\$25 For Initial Visit	1 Visit
Annual Medicare Wellness Benefit	\$25 For One Annual Visit	1 Visit
Additional Preventive Care Benefits	\$10 Per Completed Screening	5 Screenings

TERMINATION

Termination of Your Policy: Your Policy will terminate on the premium renewal date of any premium due but not paid, subject to the Grace Period provision.

DEFINITIONS

AMBULATORY SURGICAL CENTER (ASC) means a medical facility designed and equipped to handle surgery, pain management, and certain diagnostic procedures that do not require overnight hospitalization. Most patients who are in relatively good health may receive treatment at ambulatory surgery centers. The centers may be part of a community general hospital, a specialty hospital, or an independent medical facility with prearranged hospital support. The centers are staffed with health professionals as in conventional surgery departments.

CALENDAR YEAR means the period beginning on the Policy Effective Date and ending December 31 of that year. Thereafter it is the period from January 1 through December 31 of each following year.

COMPLICATIONS OF PREGNANCY means any condition that requires medical treatment or Hospital Confinement prior to or subsequent to the termination of the pregnancy whose diagnosis is distinct from, but is adversely affected by the pregnancy. Such conditions include, but are not limited to:

- 1) acute nephritis;
- 2) nephrosis;
- 3) cardiac decompensation;
- 4) missed abortion; and
- 5) similar conditions of comparable severity.

A complication of pregnancy will also include nonelective cesarean section or termination of pregnancy that occurs during a period of gestation when a viable birth is possible. "Complications of Pregnancy" will not include:

- 1) false labor;
- 2) occasional spotting;
- 3) prescribed bed rest;
- 4) morning Sickness; or
- 5) similar conditions that are common to the care of a difficult pregnancy.

DAILY HOSPITAL BENEFIT AMOUNT means the amount We will pay each day when Hospital Confined. The Daily Hospital Benefit Amount is shown in the Policy Schedule.

DOCTOR means any licensed practitioner of the healing arts operating within the scope of his or her license in treating any Injury/Accident or Sickness. It does not include a member of Your Immediate Family.

EMERGENCY ROOM means a hospital room or area staffed and equipped for the reception and treatment of persons with conditions (as illness or trauma) requiring immediate medical care.

HOSPITAL means an institution which operates pursuant to law that has organized facilities for the care and treatment of sick and injured persons on a resident or inpatient basis, including facilities for diagnosis and surgery under the supervision of a staff of one (1) or more Doctors and which provides twenty-four (24) hour nursing service by registered nurses on duty or call. Hospital does not mean convalescent, nursing, rest or extended care facilities or facilities operated exclusively for treatment of the aged, drug addicts or alcoholics, even though such facilities are operated as a separate institution by a Hospital.

HOSPITAL CONFINEMENT/CONFINED means confinement in a Hospital as a resident bed patient for a period of twenty-four (24) consecutive hours or longer. Observation days are not considered to be a Hospital Confinement and will not be payable.

IMMEDIATE FAMILY means a person that is related to You by blood, marriage or adoption, including, but not limited to:

- 1) You or Your spouse;
- 2) Your or Your spouse's parents;
- 3) Your or Your spouse's grandparents;
- 4) Your or Your spouse's children;
- 5) Your or Your spouse's grandchildren; or
- 6) Your or Your spouse's siblings.

INJURY/ACCIDENT means an accidental bodily injury sustained by You that is the direct cause of loss, independent of disease or bodily infirmity. The loss must begin while Your insurance under this Policy is in force.

INSURED means the person named as the Insured in the Policy Schedule.

MAXIMUM PER CALENDAR YEAR means the maximum amount We will pay each Calendar Year for covered services. The Maximum Per Calendar Year is shown in the Policy Schedule.

PRIMARY CARE PHYSICIAN means a Doctor, such as a family practitioner or internist who:

- 1) is chosen by an individual to provide continuous medical care;
- 2) is trained to treat a wide variety of health-related problems; and
- 3) is one who usually is the first health professional to examine a patient and who recommends secondary care physicians.

A Primary Care Physician is not a medical or surgical specialist or a member of Your Immediate Family.

SICKNESS means an illness or a disease that results in loss covered by the Policy. The loss must begin while the Policy is in force.

WE, OUR and **US** means Equitable Life & Casualty Insurance Company.

YOU, YOUR and **YOURS** means the Insured named in the Policy Schedule.

BENEFITS

The Policy will only pay the following benefits for loss that begins while the Policy is in force:

- 1) Daily Hospital Indemnity Benefit;
- 2) Ambulance Benefit;
- 3) Emergency Room Benefit;
- 4) Hospital Inpatient or Ambulatory Surgical Center (ASC) Surgical Benefit;
- 5) Hospital Outpatient or Ambulatory Surgical Center (ASC) Laboratory and Radiology Benefit;
- 6) Primary Care Physician Benefit;
- 7) Skilled Nursing Benefit;
- 8) Welcome to Medicare Benefit;
- 9) Annual Medicare Wellness Benefit; and
- 10) Additional Preventive Care Benefits.

LIMITATION ON BENEFITS

We will pay the benefit amounts payable under this Policy for the loss incurred by You.

We will not pay more than the selected benefit amounts payable under this Policy as shown in the Policy Schedule.

All benefits are subject to the definitions, limitations, exclusions and all other provisions of this Policy.

BENEFIT PROVISIONS

1) Daily Hospital Indemnity Benefit

We will pay You the Daily Hospital Indemnity Benefit shown in the Policy Schedule for each day You are Confined in a Hospital due to an Injury/Accident or Sickness. This benefit is payable up to five (5) days per Calendar Year, and no more than a maximum of two-hundred (200) days during Your lifetime.

2) Ambulance Benefit

We will pay You the Ambulance Benefit shown in the Policy Schedule if a licensed surface or air ambulance service transports You to or from a Hospital where You are Confined as an inpatient due to an Injury/Accident or Sickness. Any ambulance service must be necessary to protect Your health and safety when other reasonable and customary travel methods are not available. This benefit is payable up to three (3) ambulance trips per Calendar Year.

3) Emergency Room Benefit

We will pay You the Emergency Room Benefit shown in the Policy Schedule for services You receive in a Hospital emergency room or Hospital affiliated emergency care facility due to a Injury/Accident or Sickness, provided the Emergency treatment is followed within twenty-four (24) hours by a Hospital Confinement. This benefit is payable up to 4 times per Calendar Year.

4) Hospital Inpatient or Ambulatory Surgical Center (ASC) Surgical Benefit

We will pay You 10% of the scheduled benefit amount shown in the Medicare Fee Schedule for surgical procedures performed by a Doctor when the procedure is performed in a Hospital inpatient or Ambulatory Surgical Center setting, up to the Calendar Year maximum benefit amount shown in the Policy Schedule.

5) Hospital Outpatient or Ambulatory Surgical Center (ASC) Laboratory & Radiology Benefit

We will pay You the Hospital Outpatient or ASC Laboratory & Radiology Benefit shown in the Policy Schedule for laboratory screenings and testing, x-rays or radiological tests received in an outpatient department of a Hospital or an Ambulatory Surgical Center (ASC), up to the Calendar Year maximum benefit amount shown in the Policy Schedule.

6) Primary Care Physician Office Visit Benefit

We will pay You the Primary Care Physician Office Visit Benefit shown in the Policy Schedule for each office visit when You receive medical services from Your Primary Care Physician, up to the maximum number of visits per Calendar Year shown in the Policy Schedule.

Payment of benefits for Primary Care Physician Office Visit (Benefit 6) and Your Welcome to Medicare and/or Annual Medicare Wellness benefits (Benefits 8 & 9) cannot be combined during the same visit.

7) Skilled Nursing Benefit

We will pay You the daily Skilled Nursing Benefit shown in the Policy Schedule when You are admitted to a Skilled Nursing Facility following a Hospital Confinement for which benefits were paid under this Policy.

The benefit is only payable when:

- a) You have first been Hospital Confined for three (3) or more consecutive days for which benefits were paid under this Policy;
- b) The Skilled Nursing Facility confinement begins within thirty (30) days after such Hospital Confinement;
- c) The Skilled Nursing Facility confinement is for the same Injury/Accident or Sickness as the Hospital Confinement; and
- d) Your Doctor certifies the need for the Skilled Nursing Facility confinement.

This benefit is payable for up to twenty (20) days per Calendar Year.

8. Welcome To Medicare Benefit

We will pay You the Welcome to Medicare Benefit shown in the Policy Schedule for an initial preventive exam when You first become eligible for Medicare. The benefit is payable during the first twelve (12) months of Your Medicare Part B coverage when You visit Your Primary Care Physician for Your initial preventive exam.

9. Annual Medicare Wellness Benefit

We will pay You the Annual Medicare Wellness Benefit shown in the Policy Schedule for one annual Medicare wellness visit to Your Primary Care Physician. This benefit is payable once every twelve (12) months after the first twelve (12) months of Your Medicare Part B coverage.

10. Additional Preventive Care Benefits

We will pay the Additional Preventive Care Benefits shown in the Policy Schedule when You complete any one of the following covered preventive care services:

- a) Mammogram,
- b) Diabetes Screening;
- c) Prostate Cancer Screening (PSA Test Only);
- d) Colorectal Cancer Screening;
- e) Glaucoma Screening;
- f) Pneumonia Vaccine;
- g) Flu Vaccine;
- h) Osteoporosis Testing;
- i) Cervical & Vaginal Cancer Screening; and
- j) Cardiovascular Screening.

The benefit is limited to a maximum of five (5) preventive screenings per Calendar Year.

EXCLUSIONS

We will not pay benefits for:

- 1) Treatment, services or supplies which:
 - a) Are not prescribed by a Doctor as necessary to treat an Injury/Accident or Sickness;
 - b) Are received without charge or legal obligation to pay;
 - c) Would not routinely be paid in the absence of insurance;
 - d) Are received from any member of Your Immediate Family;
 - e) Are received outside the United States; or
 - f) Are incurred while this Policy is not in force.
- 2) Expenses incurred as a result of loss due to war, or any action of war, declared or undeclared; service in the armed forces of any country.
- 3) Expenses incurred as a result of committing or attempting to commit an assault or felony or participating in a riot or civil commotion.
- 4) Expenses incurred as a result of suicide or intentionally self-inflicted injury while sane.
- 5) Cosmetic surgery other than:
 - a) Reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or
 - b) Reconstructive surgery because of a congenital disease or anomaly.
- 6) Injury/Accident due to being legally intoxicated, as defined by the jurisdiction in which an Injury/Accident occurs.
- 7) Loss due to voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Doctor.
- 8) Loss due to mental illness or nervous disorders without demonstrable organic disease (loss due to Parkinson's Disease, Alzheimer's Disease or senile dementia is covered).
- 9) Loss due to normal pregnancy and childbirth; Complications of Pregnancy, however, will be covered as a Sickness.

HOSPITAL INPATIENT OR AMBULATORY SURGICAL CENTER SURGICAL BENEFIT EXCLUSIONS

The following exclusions are in addition to the exclusions listed above. We will not pay benefits for:

- 1) Surgery for corns, calluses and bunions; deviated nasal septum, including submucous resection and/or other surgical corrections thereof unless due to Injury occurring while this Policy is in force.
- 2) Surgery for removal of breast implants. This exclusion shall not apply to the removal of breast implants for the treatment of a covered Injury/Accident or Sickness, unless the implants were implanted solely for cosmetic purposes and not for surgically performed reconstruction resulting from an Injury/Accident or Sickness.
- 3) Surgery for non-malignant warts, moles, boils and lesions unless deemed necessary by your Doctor.
- 4) Surgery for sex transformation or reversal thereof.
- 5) Dental surgery except oral surgery for excision of tumors, growths and cysts of the jaw and mouth and surgery to sound natural teeth made necessary by injury.

PRE-EXISTING CONDITIONS LIMITATION

Pre-Existing Condition: An Injury/Accident or Sickness, disclosed or not disclosed on the application, for which medical care, treatment, diagnosis or advice was received or recommended within the six (6) month period immediately prior to Your Effective Date of coverage under this Policy; or the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the six (6) months prior to Your Effective Date of coverage under this Policy. Treatment includes the taking of prescription drugs or medicines. Pre-Existing Conditions are not covered unless the loss begins more than six (6) months after Your Effective Date of coverage.

CLAIM PROVISIONS

NOTICE OF CLAIM: Written notice of claim must be sent to Us at Our Administrative Office within **thirty (30) days** after the start of a covered loss. The notice must include Your name and Policy number. If notice cannot reasonably be given within that time, You must send the notice as soon as possible.

PROOF OF LOSS: Written proof of loss must be furnished to Us within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time, provided proof is furnished as soon as is reasonably possible; and, in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. If You are legally incapable of submitting such proof, it may be submitted at any time that it is reasonably possible to do so.

CLAIM FORMS: We will send You claim forms when We receive written notice of claim. If forms are not received within fifteen (15) days after written notice of claim is sent, then proof of claim will be met by giving Us a written statement of the type and the extent of the services. You must send such proof within the time limit stated above in the Proof of Loss provision.

PAYMENT OF CLAIMS: When We receive written proof of claim, We will pay any benefits due.

We will pay benefits to You, if living, or to Your estate. If benefits are payable to Your estate, We may pay up to \$1,000.00 to any relative of Yours whom We find is entitled to them. Any payment made in good faith will fully discharge Us to the extent of the payment.

TIME OF PAYMENT OF CLAIMS: Benefits payable under the Policy will be paid promptly following receipt of written Proof of Loss.

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

PHYSICAL EXAMINATIONS AND AUTOPSY: We have the right to have a Doctor of Our choice examine You as often as reasonably necessary while a claim is pending. Any such examinations will be made at Our expense. In the event of Your death, We may also have an autopsy made at Our expense unless prohibited by law.

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

CLAIM DENIAL: 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.

PREMIUMS

PREMIUM PAYMENTS: You are to pay each premium on or before its due date. A due date is the first day following the end of the period for which the preceding premium was paid. Premiums may be paid for twelve (12), six (6), or three (3) month periods. We will also accept monthly premiums when paid by electronic funds transfer or when paid otherwise with Our prior approval.

GRACE PERIOD: We will grant a Grace Period of thirty-one (31) days for each premium payment after the first premium payment. Coverage remains in force during the Grace Period.

NOTICE OF LAPSE: We will provide You and any third party You have selected with notice of termination for non-payment of premium thirty (30) days after a premium is due. This notice shall be given by first class United States mail and will not be given until thirty (30) days after the premium is due and unpaid. Notice will be deemed to have been given as of seven (7) days after the date of mailing.

REINSTATEMENT: If a premium is not paid before the Grace Period ends, this Policy will lapse. Later acceptance of a premium by Us without asking for an application for Reinstatement, will reinstate this Policy as of 12:01 at Your residence on the day after the date We receive the premium. If You are asked for an application, a conditional receipt for the premium will be given to You. If the application is approved, this Policy will be reinstated as of 12:01 at Your residence on the day after the date the Reinstatement application is approved. Lacking such approval, this Policy will be reinstated on the 45th day after the date of the receipt unless We write You of Our disapproval before that date.

The reinstated Policy will only cover a loss that results from an Injury/Accident sustained after the date of Reinstatement, or a Sickness that begins more than ten (10) days after such date. In all other respects, Your rights and Our rights will remain the same after You have satisfied 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 before the date of Reinstatement.

MISSTATEMENT OF AGE: If Your age has been misstated, the benefits may be adjusted, based on the relationship of the premium paid to the premium that should have been paid based on the correct age. If no insurance would have been available, We will refund the difference between the premiums You have paid less any benefits paid.

REFUND OF PREMIUM AT DEATH: We will refund that part of any premium paid which covers a period beyond the end of the Policy month of Your death.

GENERAL PROVISIONS

THE CONTRACT: The entire contract includes:

- 1) this Policy;
- 2) any amendments to this Policy signed by any one of Our executive officers;
- 3) Your application for insurance under this Policy.

No insurance producer has authority to change or to waive any contract provisions.

We consider any statement made by You, in the absence of fraud, to be a representation and not a warranty. No statement will be used to void the insurance, reduce benefits, or deny a claim unless:

- 1) the statement is in writing; and
- 2) a copy of that statement is given to You.

TIME LIMIT ON CERTAIN DEFENSES: We may void Your coverage or deny any claim for loss which starts within the first two (2) years of the Effective Date of Your coverage. We may do so only if We determine there was material misrepresentation that would have caused the application for this insurance to be declined. After two (2) years from the Effective Date of Your coverage only fraudulent misstatements in the application relating to Your health may be used to void Your coverage or deny any claim for loss that starts after the two (2) year period.

OTHER INSURANCE WITH US: If You are Insured with Us under more than one Policy of this type, only one Policy, to be chosen by You or Your estate, will be effective. The insurance under the other policies will be deemed to have ceased as of the date the duplication began. We will refund any premium paid to Us and not earned due to this clause. The refund will be based on the number of full months since the duplication began.

CONFORMITY WITH STATE LAWS: Any provision of this Policy which, on the Effective Date, is in conflict with the laws of the state in which it is delivered is amended to conform to the minimum requirements of such laws.

OUTLINE OF COVERAGE

Hospital Confinement Indemnity Policy
Premiums May Be Changed By Class
Policy Form ELCHIP

EQUITABLE LIFE & CASUALTY INSURANCE COMPANY

[Administrative Office: P.O. Box 16958, Clearwater FL, 33766-6958]
[(855) 755-4663]

KEEP THIS OUTLINE FOR YOUR RECORDS

THIS IS NOT A MEDICARE SUPPLEMENT POLICY

THIS IS A LIMITED BENEFIT POLICY - 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. Your policy sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you REVIEW YOUR POLICY CAREFULLY!

LIMITED BENEFIT COVERAGE

This policy is designed to provide, to the person insured, Limited Benefit Coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered Injury/Accident or Sickness, subject to any limitations set forth in the policy. Such policies do provide additional benefits other than the fixed daily benefit for hospital confinements, which are described below.

BENEFITS

The policy will only pay the following benefits:

1. Daily Hospital Indemnity Benefit
2. Ambulance Benefit
3. Emergency Room Benefit
4. Hospital Inpatient or ASC Surgical Benefit
5. Hospital Outpatient or ASC Laboratory & Radiology Benefit
6. Primary Care Physician Office Visit Benefit
7. Skilled Nursing Benefit
8. Welcome to Medicare Benefit
9. Annual Medicare Wellness Benefit
10. Additional Preventive Care Benefits

BENEFIT 1: DAILY HOSPITAL INDEMNITY BENEFIT

We will pay you the Daily Hospital Indemnity Benefit for each day you are Confined in a Hospital due to an Injury/Accident or Sickness. This benefit is payable up to 5 days per Calendar Year, and no more than a maximum of 200 days during your lifetime.

BENEFIT 2: AMBULANCE BENEFIT

We will pay you the Ambulance Benefit if a licensed surface or air ambulance service transports you to or from a Hospital where you are Confined as an inpatient due to an Injury/Accident or Sickness. Any ambulance service must be necessary to protect your health and safety when other reasonable and customary travel methods are not available. This benefit is payable up to 3 ambulance trips per Calendar Year.

BENEFIT 3: EMERGENCY ROOM BENEFIT

We will pay you the Emergency Room Benefit for services you receive in a Hospital emergency room or Hospital affiliated emergency care facility due to an Injury/Accident or Sickness, provided the Emergency treatment is followed within 24 hours by a Hospital Confinement. This benefit is payable up to 4 times per Calendar Year.

BENEFIT 4: HOSPITAL INPATIENT OR AMBULATORY SURGICAL CENTER (ASC) SURGICAL BENEFIT

We will pay you 10% of the scheduled benefit amount shown in the Medicare fee schedule for surgical procedures performed by a Doctor when the procedure is performed in a Hospital inpatient or Ambulatory Surgical Center setting, up to the Calendar Year maximum benefit amount shown in the benefit table below.

BENEFIT 5: HOSPITAL OUTPATIENT OR AMBULATORY SURGICAL CENTER (ASC) LABORATORY & RADIOLOGY BENEFIT

We will pay you the Hospital Outpatient or ASC Laboratory & Radiology Benefit for laboratory screenings and testing, x-rays or radiological tests received in an outpatient department of a Hospital or an Ambulatory Surgical Center (ASC), up to the Calendar Year maximum benefit amount shown in the benefit table below.

BENEFIT 6: PRIMARY CARE PHYSICIAN OFFICE VISIT BENEFIT

We will pay you the Primary Care Physician Office Visit Benefit for each office visit when you receive medical services from your Primary Care Physician, up to the maximum number of visits per Calendar Year shown in the benefit table below.

BENEFIT 7: SKILLED NURSING BENEFIT

We will pay you the daily Skilled Nursing Benefit when you are admitted to a Skilled Nursing Facility following a Hospital Confinement for which benefits were paid under the policy.

The benefit is only payable when:

- a) You have first been Hospital Confined for 3 or more consecutive days for which benefits are paid under the policy;
- b) The Skilled Nursing Facility confinement begins within 30 days after such Hospital Confinement;
- c) The Skilled Nursing Facility confinement is for the same Injury/Accident or Sickness as the Hospital Confinement; and
- d) Your Doctor certifies the need for the Skilled Nursing Facility confinement.

This benefit is payable for up to 20 days per Calendar Year.

BENEFIT 8: WELCOME TO MEDICARE BENEFIT

We will pay you the Welcome to Medicare Benefit for an initial preventive exam when you first become eligible for Medicare. The benefit is payable during the first 12 months of your Medicare Part B coverage when you visit your Primary Care Physician for your initial preventive exam.

BENEFIT 9: ANNUAL MEDICARE WELLNESS BENEFIT

We will pay you the Annual Medicare Wellness Benefit for one annual Medicare wellness visit to your Primary Care Physician. This benefit is payable once every 12 months after the first 12 months of your Medicare Part B coverage.

Payment of benefits for Primary Care Physician Office Visit (Benefit 6) and your Welcome to Medicare and/or Annual Medicare Wellness benefits (Benefits 8 & 9) cannot be combined during the same visit.

BENEFIT 10: ADDITIONAL PREVENTIVE CARE BENEFITS

We will pay the Additional Preventive Care Benefits when you complete any one of the following covered preventive care services:

- a) Mammogram
- b) Diabetes Screening
- c) Prostate Cancer Screening (PSA Test Only)
- d) Colorectal Cancer Screening
- e) Glaucoma Screening
- f) Pneumonia Vaccine
- g) Flu Vaccine
- h) Osteoporosis Testing
- i) Cervical & Vaginal Cancer Screening
- j) Cardiovascular Screening

The benefit is limited to a maximum of five (5) preventive screenings per Calendar Year.

BENEFIT LEVELS

	Policy Benefits	Maximum Per Calendar Year
Daily Hospital Indemnity Benefit	\$100, \$125 or \$250 Per Day	5 Days
Ambulance Benefit	\$75, \$100 or \$125 Per Trip	3 Trips
Emergency Room Benefit	\$25 or \$50 Per Admission	4 Admissions
Hospital Inpatient or ASC Surgical Benefit	10% of Medicare Fee Schedule Amount	\$500, \$1,000 or \$2,500
Hospital Outpatient or ASC Laboratory & Radiology Benefit	\$20, \$25 or \$30 Per Outpatient Visit	\$500, \$700 or \$900
Primary Care Physician Office Visit Benefit	\$15, \$20 or \$25 Per Visit	4,6 or 8 Visits
Skilled Nursing Benefit	\$20, \$25 or \$60 Per Day	20 Days
Welcome to Medicare Benefit	\$25 For Initial Visit	1 Visit
Annual Medicare Wellness Benefit	\$25 For One Annual Visit	1 Visit
Additional Preventive Care Benefits	\$10 Per Completed Screening	5 Screenings

DEFINITIONS

AMBULATORY SURGICAL CENTER (ASC) means a medical facility designed and equipped to handle surgery, pain management, and certain diagnostic procedures that do not require overnight hospitalization. Most patients who are in relatively good health may receive treatment at ambulatory surgery centers. The centers may be part of a community general hospital, a specialty hospital, or an independent medical facility with prearranged hospital support. The centers are staffed with health professionals as in conventional surgery departments.

CALENDAR YEAR means the period beginning on the policy effective date and ending December 31 of that year. Thereafter it is the period from January 1 through December 31 of each following year.

COMPLICATIONS OF PREGNANCY means any condition that requires medical treatment or Hospital Confinement prior to or subsequent to the termination of the pregnancy whose diagnosis is distinct from, but is adversely affected by the pregnancy. Such conditions include, but are not limited to: (1) acute nephritis; (2) nephrosis; (3) cardiac decompensation; (4) missed abortion; and, (5) similar conditions of comparable severity. A complication of pregnancy will also include nonelective cesarean section or termination of pregnancy that occurs during a period of gestation when a viable birth is possible. "Complications of Pregnancy" will not include: (1) false labor; (2) occasional spotting; (3) prescribed bed rest; (4) morning Sickness; or, (5) similar conditions that are common to the care of a difficult pregnancy.

DAILY HOSPITAL BENEFIT AMOUNT means the amount we will pay each day when Hospital Confined.

DOCTOR means any licensed practitioner of the healing arts operating within the scope of his or her license in treating any Injury or Sickness. It doesn't include a member of Your Immediate Family.

EMERGENCY ROOM means a hospital room or area staffed and equipped for the reception and treatment of persons with conditions (as illness or trauma) requiring immediate medical care.

HOSPITAL means an institution which operates pursuant to law that has organized facilities for the care and treatment of sick and injured persons on a resident or inpatient basis, including facilities for diagnosis and surgery under the supervision of a staff of one (1) or more Doctors and which provides 24 hour nursing services by registered nurses on duty or call. Hospital does not mean convalescent, nursing, rest or extended care facilities or facilities operated exclusively for treatment of the aged, drug addicts or alcoholics, even though such facilities are operated as a separate institution by a Hospital.

HOSPITAL CONFINEMENT/CONFINED means confinement in a Hospital as a resident bed patient for a period of 24 consecutive hours or longer. Observation days are not considered to be Hospital Confined and will not be payable.

IMMEDIATE FAMILY means a person that is related to you by blood, marriage or adoption, including, but not limited to, you or your spouse, your or your spouse's parents, your or your spouse's grandparents, your or your spouse's children, your or your spouse's grandchildren, or your or your spouse's siblings.

INJURY/ACCIDENT means an accidental bodily injury sustained by you that is the direct cause of loss, independent of disease or bodily infirmity. The loss must begin while your insurance under the policy is in force.

MAXIMUM PER CALENDAR YEAR means the maximum amount We will pay each Calendar Year for covered services. The Maximum per calendar year is shown in the benefit table above.

PRIMARY CARE PHYSICIAN means a Doctor, such as a family practitioner or internist who is chosen by an individual to provide continuous medical care, trained to treat a wide variety of health-related problems, and one who usually is the first health professional to examine a patient and who recommends secondary care physicians. A Primary Care Physician is not a medical or surgical specialist or a member of Your Immediate Family.

SICKNESS means an illness or a disease that results in loss covered by the policy. The loss must begin while the policy is in force.

LIMITATIONS AND EXCLUSIONS

PRE-EXISTING CONDITIONS LIMITATION

Pre-Existing Condition: An Injury/Accident or Sickness, disclosed or not disclosed on the application, for which medical care, treatment, diagnosis or advice was received or recommended within the 6 month period immediately prior to your effective date of coverage under the policy; or the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 6 months prior to your effective date of coverage under the policy. Treatment includes the taking of prescription drugs or medicines. Pre-Existing Conditions are not covered unless the loss begins more than 6 months after your effective date of coverage.

EXCLUSIONS

We will not pay benefits for:

- 1) Treatment, services or supplies which:
 - a) Are not prescribed by a Doctor as necessary to treat an Injury/Accident or Sickness;
 - b) Are received without charge or legal obligation to pay;
 - c) Would not routinely be paid in the absence of insurance;
 - d) Are received from any member of Your Immediate Family;
 - e) Are received outside the United States; or
 - f) Are incurred while the policy is not in force.
- 2) Expenses incurred as a result of loss due to war, or any action of war, declared or undeclared; service in the armed forces of any country.
- 3) Expenses incurred as a result of committing or attempting to commit an assault or felony or participating in a riot or civil commotion.
- 4) Expenses incurred as a result of suicide or intentionally self-inflicted injury while sane.
- 5) Cosmetic surgery other than:
 - a) Reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or
 - b) Reconstructive surgery because of a congenital disease or anomaly.
- 6) Injury/Accident due to being legally intoxicated, as defined by the jurisdiction in which an Injury/Accident occurs.
- 7) Loss due to voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Doctor.
- 8) Loss due to mental illness or nervous disorders without demonstrable organic disease (loss due to Parkinson's Disease, Alzheimer's Disease or senile dementia is covered).
- 9) Loss due to normal pregnancy and childbirth; Complications of Pregnancy, however, will be covered as a Sickness.

HOSPITAL INPATIENT OR AMBULATORY SURGICAL CENTER SURGICAL BENEFIT EXCLUSIONS

The following exclusions are in addition to the exclusions listed above. We will not pay benefits for:

- 1) Surgery for corns, calluses and bunions; deviated nasal septum, including submucous resection and/or other surgical corrections thereof unless due to Injury occurring while the policy is in force.
- 2) Surgery for removal of breast implants. This exclusion shall not apply to the removal of breast implants for the treatment of a covered Injury/Accident or Sickness, unless the implants were implanted solely for cosmetic purposes and not for surgically performed reconstruction resulting from an Injury/Accident or Sickness.
- 3) Surgery for non-malignant warts, moles, boils and lesions unless deemed necessary by your Doctor.
- 4) Surgery for sex transformation or reversal thereof.
- 5) Dental surgery except oral surgery for excision of tumors, growths and cysts of the jaw and mouth and surgery to sound natural teeth made necessary by Injury/Accident.

GUARANTEED RENEWABLE FOR LIFE

Your policy will stay in force by paying the renewal premium at the intervals available to you at time of renewal. You must pay the renewal premium by its due date or during the 31 days that follow. We cannot cancel or refuse to renew the policy or place any restrictions on it if you pay your premiums on time.

REINSTATEMENT

Reinstatements may be made within 60 days of the due date of the premium in default. Payment of back premiums with satisfactory evidence of insurability is required.

PREMIUMS SUBJECT TO CHANGE

We will not change the premium for the policy during your first year of coverage. Thereafter, we may change the premium rates for the policy by giving you at least 31 days prior written notice of any change in the renewal premium. We can only change the premium if we change it for all policies like yours in your state on a class basis.

INITIAL PREMIUM

Hospital Confinement Indemnity Policy: \$ _____

APPLICATION

Hospital Confinement Indemnity Policy

Equitable Life & Casualty Insurance Company

[Administrative Office: P.O. Box 16958, Clearwater, FL 33766-6958]

[Phone: (855) 775-4663 • Fax: (855) 367-0114]

APPLICATION FOR: New Coverage Reinstatement Change of Benefits

If reinstatement or change of benefits requested, please print policy number affected: _____

MAIL POLICY TO: Agent Insured

Part A. Applicant Information

_____	_____	_____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Last Name	First Name	MI		
_____	_____	_____		
Soc. Sec. #	Birth Date (mm/dd/yyyy)	Age		
_____	_____	_____		
_____	_____	_____	_____	_____
Street Address	City	State	Zip	
_____	_____	_____	_____	
_____	_____	_____		
Daytime Phone (please include area code)	Best Time to Call	E-Mail Address		

QUALIFYING INFORMATION

(If any answer to questions 1 thru 5 is "YES" you are **not** eligible for coverage. DO NOT SUBMIT APPLICATION.)

1. In the past 12 months have you: been confined as an inpatient to a hospital or a nursing home or have you received home health care?..... YES NO
2. In the past 24 months have you: had a heart attack, stroke, congestive heart failure, heart surgery/bypass, malignant melanoma or cancer (other than skin cancer)? YES NO
3. In the past 12 months have you: been treated for chronic obstructive lung disease, insulin dependent diabetes, dementia, Alzheimer's disease, cirrhosis, diabetes with complications or chronic liver or kidney disease; been prescribed to use oxygen?..... YES NO
4. In the past 12 months have you: had surgery which required an inpatient hospital stay or been advised to have surgery which will require an inpatient stay but have not yet done so? YES NO
5. Have you ever: been treated for or been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or HIV infection, aneurysm, cardiomyopathy, or peripheral vascular disease; been treated for drug or alcohol abuse; received an organ transplant, had an amputation due to disease, or used a defibrillator?..... YES NO

Plan Selection A B C

Will this policy replace any existing insurance with any company? YES NO
If yes, please complete the Replacement Notice.

PART B. PREMIUM

Hospital Confinement Indemnity Annual Premium for Applicant \$ _____

Premium Payment Mode Annual Semi-Annual (.520)
 Quarterly (.265) Monthly EFT (1/12)

Total Mode Premium for Applicant..... \$ _____

Total Initial Premium + one-time \$25 Application Fee \$ _____

Requested Effective Date ____ / ____ / ____

Requested Effective Date cannot be prior to the Application Date.
If no Effective Date is requested, the Effective Date will be the date of the underwriting decision to approve issuance coverage.

PART C. MONTHLY PRE-AUTHORIZED PREMIUM PAYMENT PLAN

Authorization to Honor Withdrawals to be drawn by Equitable Life & Casualty Insurance Company.

TO _____
Name of my Bank My Bank's Address City State Zip Code

As a convenience to me, I request and authorize you to charge the account shown below for premiums drawn by and payable to the order of Equitable Life & Casualty Insurance Company, Salt Lake City, Utah, provided there are sufficient funds in my account to pay the same upon presentation.

Account # _____ Bank Routing # _____

Account Type: Checking Account Savings Account Bank Draft Day (days 1-28) _____
(Attach a Voided "Sample" check if applicable, or a Deposit slip)

I agree that my rights in respect to each payment shall be the same as if it were drawn by me and signed personally by me. This authority is to remain in effect until revoked by me in writing and until you receive notice for which you agree you will be fully protected in honoring such requests. I further agree that if any such payment is not honored, whether with or without cause and whether intentionally, or inadvertently, you shall be under no liability at all although such action could result in the forfeiture of insurance.

X _____
Premium Payer's Signature (as it appears on bank records) Printed Name of Insured (if different from premium payer)

PART D. NOTICE OF LAPSE

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

I elect NOT to designate a third party designee. I elect to designate an third party designee, named below.

Last Name First Name MI Phone (please include area code)

Street Address City State Zip

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.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. 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
- 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).



Equitable Life & Casualty Insurance Company

P.O. Box 16958, Clearwater, FL 33766-6958

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE!

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Equitable Life & Casualty Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

- (1) Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy.
- (2) You may wish to secure the advice of your present insurer or its agents regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
- (3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

Date

Agent Name (Print)

Applicant's Signature

Agent Signature

Equitable Life & Casualty Insurance Company

P.O. Box 16958, Clearwater, FL 33766-6958

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE!

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

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The above "Notice to Applicant" was delivered to me on:

Date

Agent Name (Print)

Applicant's Signature

Agent Signature

SERFF Tracking #:

ELCC-128646904

State Tracking #:

Company Tracking #:

ELCHIP

State: Arkansas

Filing Company:

Equitable Life & Casualty Insurance Company

TOI/Sub-TOI: H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity

Product Name: Hospital Indemnity

Project Name/Number: ELCHIP/ELCHIP

Rate Information

Rate data applies to filing.

Filing Method: Electronic

Rate Change Type: Neutral

Overall Percentage of Last Rate Revision: 0.000%

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Equitable Life & Casualty Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking #:

ELCC-128646904

State Tracking #:**Company Tracking #:**

ELCHIP

State:

Arkansas

Filing Company:

Equitable Life & Casualty Insurance Company

TOI/Sub-TOI:

H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity

Product Name:

Hospital Indemnity

Project Name/Number:

ELCHIP/ELCHIP

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action*	Rate Action Information	Attachments
1	Approved-Closed 09/11/2012	Premium Rates	ELCHIP	New		50% LR Exh2_PremiumRateSchedule.pdf

**Equitable Life & Casualty Insurance Company
Hospital Indemnity Policy Form - ELCHIP**

**Exhibit 2
Annual Premium Rates**

Issue Age	Benefit Level		
	Plan A	Plan B	Plan C
40-59	334.80	429.60	565.20
60	344.40	441.60	584.40
61	354.00	454.80	604.80
62	364.80	468.00	626.40
63	373.20	480.00	645.60
64	382.80	492.00	664.80
65	393.60	505.20	685.20
66	403.20	518.40	706.80
67	412.80	531.60	728.40
68	421.20	541.20	746.40
69	429.60	550.80	764.40
70	438.00	561.60	783.60
71	446.40	572.40	802.80
72	454.80	582.00	822.00
73	464.40	595.20	841.20
74	474.00	607.20	859.20
75	483.60	620.40	879.60
76	493.20	633.60	898.80
77	504.00	646.80	919.20
78	511.20	656.40	936.00
79	518.40	664.80	954.00
80	525.60	674.40	970.80
81	532.80	684.00	988.80
82	541.20	693.60	1,006.80
83	548.40	703.20	1,024.80
84	555.60	712.80	1,042.80
85	564.00	722.40	1,062.00

Application Fee: \$25.00

Premium Modal Factors:

	Factor
Semi-Annual	0.520 x Annual
Quarterly	0.265 x Annual
Monthly - Direct Bill	0.090 x Annual
Monthly - Bank Draft	1/12th Annual

SERFF Tracking #:

ELCC-128646904

State Tracking #:

Company Tracking #:

ELCHIP

State: Arkansas

Filing Company:

Equitable Life & Casualty Insurance Company

TOI/Sub-TOI: H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity

Product Name: Hospital Indemnity

Project Name/Number: ELCHIP/ELCHIP

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	09/11/2012
Comments:			
Attachment(s):			
Readability Certification.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	09/11/2012
Bypass Reason:	See Form Schedule		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	09/11/2012
Bypass Reason:	See Form Schedule		
Comments:			



Ambassadors Of Caring

CERTIFICATION OF READABILITY

This is to certify that the policy form referenced below has achieved the Flesch Reading Ease Score as noted, in accordance with ACA §23-80-206.

<u>Policy Form #</u>	<u>Flesch Score</u>
ELCHIP	42.6

Dated this 22nd day of August, 2012



Kendall R. Surfass
Vice Chairman, Vice President, Secretary and General Counsel
Equitable Life & Casualty Insurance Company

SERFF Tracking #:

ELCC-128646904

State Tracking #:**Company Tracking #:**

ELCHIP

State:

Arkansas

Filing Company:

Equitable Life & Casualty Insurance Company

TOI/Sub-TOI:

H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity

Product Name:

Hospital Indemnity

Project Name/Number:

ELCHIP/ELCHIP

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
08/22/2012	Form	Policy	09/10/2012	ELCHIP.pdf (Superseded)
08/22/2012	Form	Outline of Coverage	09/25/2012	ELCHIOC.pdf (Superseded)
08/22/2012	Form	Application	09/25/2012	ELCHIAP AR.pdf (Superseded)

POLICY

for Hospital Confinement Indemnity Insurance

EQUITABLE LIFE & CASUALTY INSURANCE COMPANY

Hospital Advantage Plus Administrative Office: P.O. Box 16958, Clearwater FL, 33766-6958
(855) 755-4663

EFFECTIVE DATE: Your insurance under this Individual Policy (hereinafter referred to as the "Policy") begins at 12:01 a.m. at your residence on the Effective Date shown in the Policy Schedule.

Signed for Equitable Life & Casualty Insurance Company at Salt Lake City, Utah by:


Secretary


President

The Policy has been issued and delivered to You, named as the Insured in the Policy Schedule.

This Policy establishes that You are covered by the described insurance, subject to the terms and conditions of this Policy. Your coverage under this Policy will be renewable for Your lifetime, subject to the timely payment of the renewal premiums as they are due.

This Policy describes the benefits, important provisions, exceptions and limitations of this Policy. Insurance under this Policy is effective only if You remain Insured.

This Policy pays benefits in addition to any other health insurance You may have, including Medicare.

This Policy is NOT MEDICARE SUPPLEMENT insurance. If You are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from Us.

POLICY RENEWAL CONDITIONS – YOUR POLICY IS GUARANTEED RENEWABLE: This means You have the right to continue Your 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 may change the renewal Premium for Your Policy, but only if We change them for all policies like Yours in Your state on a Premium class basis. A Premium class is determined by factors including, but not limited to, age and the year the Policy is issued. You will be notified at least thirty-one (31) days before any Premium change. Your Premium will not increase due to a change in Your individual age or Your specific health.

ABOUT STATEMENTS MADE IN YOUR APPLICATION

Caution: This Policy was issued based upon Your answers 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. 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 within 30 days at Our Administrative Office, P.O. Box 16958, Clearwater, FL 33766-6958. If You have any questions concerning this coverage, or if We can be of any assistance, please call Us at 1-855-775-4663.

30-DAY RIGHT TO EXAMINE COVERAGE: You may cancel coverage under this Policy within thirty (30) days of receiving it by returning the Policy to Us or to the agent of record. If it is returned for cancellation, We will refund any premium paid for Your coverage, minus any paid claims. This Policy will then be void as of the Effective Date and there will be no coverage.

NOTICE TO BUYER: This Policy may not cover all of the costs associated with Hospital Confinement incurred by You during the period of coverage. You are advised to review carefully all Policy limitations and exceptions.

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POLICY SCHEDULE

Insured Name	Policy Number		Insured's Age at Date of Issue
Street Address	City	State	Zip
Initial Premium Amount \$	Premium Mode	Policy Effective Date	

	Policy Benefits	Maximum Per Calendar Year
Daily Hospital Indemnity Benefit	[\$100,\$125,\$250] Per Day	5 Days
Ambulance Benefit	[\$75,\$100,\$125] Per Trip	3 Trips
Emergency Room Benefit	[\$25,\$50] Per Admission	4 Admissions
Hospital Inpatient or ASC Surgical Benefit	10% of Medicare Fee Schedule Amount	[\$500,\$1,000,\$2,500]
Hospital Outpatient or ASC Laboratory & Radiology Benefit	[\$20,\$25,\$30] Per Outpatient Visit	[\$500,\$700,\$900]
Primary Care Physician Office Visit Benefit	[\$15,\$20,\$25] Per Visit	[4,6,8] Visits
Skilled Nursing Benefit	[\$20,\$25,\$60] Per Day	20 Days
Welcome to Medicare Benefit	\$25 For Initial Visit	1 Visit
Annual Medicare Wellness Benefit	\$25 For One Annual Visit	1 Visit
Additional Preventive Care Benefits	\$10 Per Completed Screening	5 Screenings

TERMINATION

Termination of Your Policy: Your Policy will terminate on the premium renewal date of any premium due but not paid, subject to the Grace Period provision.

DEFINITIONS

AMBULATORY SURGICAL CENTER (ASC) means a medical facility designed and equipped to handle surgery, pain management, and certain diagnostic procedures that do not require overnight hospitalization. Most patients who are in relatively good health may receive treatment at ambulatory surgery centers. The centers may be part of a community general hospital, a specialty hospital, or an independent medical facility with prearranged hospital support. The centers are staffed with health professionals as in conventional surgery departments.

CALENDAR YEAR means the period beginning on the Policy Effective Date and ending December 31 of that year. Thereafter it is the period from January 1 through December 31 of each following year.

COMPLICATIONS OF PREGNANCY means any condition that requires medical treatment or Hospital Confinement prior to or subsequent to the termination of the pregnancy whose diagnosis is distinct from, but is adversely affected by the pregnancy. Such conditions include, but are not limited to:

- 1) acute nephritis;
- 2) nephrosis;
- 3) cardiac decompensation;
- 4) missed abortion; and
- 5) similar conditions of comparable severity.

A complication of pregnancy will also include nonelective cesarean section or termination of pregnancy that occurs during a period of gestation when a viable birth is possible. "Complications of Pregnancy" will not include:

- 1) false labor;
- 2) occasional spotting;
- 3) prescribed bed rest;
- 4) morning Sickness; or
- 5) similar conditions that are common to the care of a difficult pregnancy.

DAILY HOSPITAL BENEFIT AMOUNT means the amount We will pay each day when Hospital Confined. The Daily Hospital Benefit Amount is shown in the Policy Schedule.

DOCTOR means any licensed practitioner of the healing arts operating within the scope of his or her license in treating any Injury/Accident or Sickness. It does not include a member of Your Immediate Family.

EMERGENCY ROOM means a hospital room or area staffed and equipped for the reception and treatment of persons with conditions (as illness or trauma) requiring immediate medical care.

HOSPITAL means an institution which operates pursuant to law that has organized facilities for the care and treatment of sick and injured persons on a resident or inpatient basis, including facilities for diagnosis and surgery under the supervision of a staff of one (1) or more Doctors and which provides twenty-four (24) hour nursing service by registered nurses on duty or call. Hospital does not mean convalescent, nursing, rest or extended care facilities or facilities operated exclusively for treatment of the aged, drug addicts or alcoholics, even though such facilities are operated as a separate institution by a Hospital.

HOSPITAL CONFINEMENT/CONFINED means confinement in a Hospital as a resident bed patient for a period of twenty-four (24) consecutive hours or longer. Observation days are not considered to be a Hospital Confinement and will not be payable.

IMMEDIATE FAMILY means a person that is related to You by blood, marriage or adoption, including, but not limited to:

- 1) You or Your spouse;
- 2) Your or Your spouse's parents;
- 3) Your or Your spouse's grandparents;
- 4) Your or Your spouse's children;
- 5) Your or Your spouse's grandchildren; or
- 6) Your or Your spouse's siblings.

INJURY/ACCIDENT means an accidental bodily injury sustained by You that is the direct cause of loss, independent of disease or bodily infirmity. The loss must begin while Your insurance under this Policy is in force.

INSURED means the person named as the Insured in the Policy Schedule.

MAXIMUM PER CALENDAR YEAR means the maximum amount We will pay each Calendar Year for covered services. The Maximum Per Calendar Year is shown in the Policy Schedule.

PRIMARY CARE PHYSICIAN means a Doctor, such as a family practitioner or internist who:

- 1) is chosen by an individual to provide continuous medical care;
- 2) is trained to treat a wide variety of health-related problems; and
- 3) is one who usually is the first health professional to examine a patient and who recommends secondary care physicians.

A Primary Care Physician is not a medical or surgical specialist or a member of Your Immediate Family.

SICKNESS means an illness or a disease that results in loss covered by the Policy. The loss must begin while the Policy is in force.

WE, OUR and **US** means Equitable Life & Casualty Insurance Company.

YOU, YOUR and **YOURS** means the Insured named in the Policy Schedule.

BENEFITS

The Policy will only pay the following benefits for loss that begins while the Policy is in force:

- 1) Daily Hospital Indemnity Benefit;
- 2) Ambulance Benefit;
- 3) Emergency Room Benefit;
- 4) Hospital Inpatient or Ambulatory Surgical Center (ASC) Surgical Benefit;
- 5) Hospital Outpatient or Ambulatory Surgical Center (ASC) Laboratory and Radiology Benefit;
- 6) Primary Care Physician Benefit;
- 7) Skilled Nursing Benefit;
- 8) Welcome to Medicare Benefit;
- 9) Annual Medicare Wellness Benefit; and
- 10) Additional Preventive Care Benefits.

LIMITATION ON BENEFITS

We will pay the benefit amounts payable under this Policy for the loss incurred by You.

We will not pay more than the selected benefit amounts payable under this Policy as shown in the Policy Schedule.

All benefits are subject to the definitions, limitations, exclusions and all other provisions of this Policy.

BENEFIT PROVISIONS

1) Daily Hospital Indemnity Benefit

We will pay You the Daily Hospital Indemnity Benefit shown in the Policy Schedule for each day You are Confined in a Hospital due to an Injury/Accident or Sickness. This benefit is payable up to five (5) days per Calendar Year, and no more than a maximum of two-hundred (200) days during Your lifetime.

2) Ambulance Benefit

We will pay You the Ambulance Benefit shown in the Policy Schedule if a licensed surface or air ambulance service transports You to or from a Hospital where You are Confined as an inpatient due to an Injury/Accident or Sickness. Any ambulance service must be necessary to protect Your health and safety when other reasonable and customary travel methods are not available. This benefit is payable up to three (3) ambulance trips per Calendar Year.

3) Emergency Room Benefit

We will pay You the Emergency Room Benefit shown in the Policy Schedule for services You receive in a Hospital emergency room or Hospital affiliated emergency care facility due to a Injury/Accident or Sickness, provided the Emergency treatment is followed within twenty-four (24) hours by a Hospital Confinement. This benefit is payable up to 4 times per Calendar Year.

4) Hospital Inpatient or Ambulatory Surgical Center (ASC) Surgical Benefit

We will pay You 10% of the scheduled benefit amount shown in the Medicare Fee Schedule for surgical procedures performed by a Doctor when the procedure is performed in a Hospital inpatient or Ambulatory Surgical Center setting, up to the Calendar Year maximum benefit amount shown in the Policy Schedule.

5) Hospital Outpatient or Ambulatory Surgical Center (ASC) Laboratory & Radiology Benefit

We will pay You the Hospital Outpatient or ASC Laboratory & Radiology Benefit shown in the Policy Schedule for laboratory screenings and testing, x-rays or radiological tests received in an outpatient department of a Hospital or an Ambulatory Surgical Center (ASC), up to the Calendar Year maximum benefit amount shown in the Policy Schedule.

6) Primary Care Physician Office Visit Benefit

We will pay You the Primary Care Physician Office Visit Benefit shown in the Policy Schedule for each office visit when You receive medical services from Your Primary Care Physician, up to the maximum number of visits per Calendar Year shown in the Policy Schedule.

Payment of benefits for Primary Care Physician Office Visit (Benefit 6) and Your Welcome to Medicare and/or Annual Medicare Wellness benefits (Benefits 8 & 9) cannot be combined during the same visit.

7) Skilled Nursing Benefit

We will pay You the daily Skilled Nursing Benefit shown in the Policy Schedule when You are admitted to a Skilled Nursing Facility following a Hospital Confinement for which benefits were paid under this Policy.

The benefit is only payable when:

- a) You have first been Hospital Confined for three (3) or more consecutive days for which benefits were paid under this Policy;
- b) The Skilled Nursing Facility confinement begins within thirty (30) days after such Hospital Confinement;
- c) The Skilled Nursing Facility confinement is for the same Injury/Accident or Sickness as the Hospital Confinement; and
- d) Your Doctor certifies the need for the Skilled Nursing Facility confinement.

This benefit is payable for up to twenty (20) days per Calendar Year.

8. Welcome To Medicare Benefit

We will pay You the Welcome to Medicare Benefit shown in the Policy Schedule for an initial preventive exam when You first become eligible for Medicare. The benefit is payable during the first twelve (12) months of Your Medicare Part B coverage when You visit Your Primary Care Physician for Your initial preventive exam.

9. Annual Medicare Wellness Benefit

We will pay You the Annual Medicare Wellness Benefit shown in the Policy Schedule for one annual Medicare wellness visit to Your Primary Care Physician. This benefit is payable once every twelve (12) months after the first twelve (12) months of Your Medicare Part B coverage.

10. Additional Preventive Care Benefits

We will pay the Additional Preventive Care Benefits shown in the Policy Schedule when You complete any one of the following covered preventive care services:

- a) Mammogram,
- b) Diabetes Screening;
- c) Prostate Cancer Screening (PSA Test Only);
- d) Colorectal Cancer Screening;
- e) Glaucoma Screening;
- f) Pneumonia Vaccine;
- g) Flu Vaccine;
- h) Osteoporosis Testing;
- i) Cervical & Vaginal Cancer Screening; and
- j) Cardiovascular Screening.

The benefit is limited to a maximum of five (5) preventive screenings per Calendar Year.

EXCLUSIONS

We will not pay benefits for:

- 1) Treatment, services or supplies which:
 - a) Are not prescribed by a Doctor as necessary to treat an Injury/Accident or Sickness;
 - b) Are received without charge or legal obligation to pay;
 - c) Would not routinely be paid in the absence of insurance;
 - d) Are received from any member of Your Immediate Family;
 - e) Are received outside the United States; or
 - f) Are incurred while this Policy is not in force.
- 2) Expenses incurred as a result of loss due to war, or any action of war, declared or undeclared; service in the armed forces of any country.
- 3) Expenses incurred as a result of committing or attempting to commit an assault or felony or participating in a riot or civil commotion.
- 4) Expenses incurred as a result of suicide or intentionally self-inflicted injury while sane.
- 5) Cosmetic surgery other than:
 - a) Reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or
 - b) Reconstructive surgery because of a congenital disease or anomaly.
- 6) Injury/Accident due to being legally intoxicated, as defined by the jurisdiction in which an Injury/Accident occurs.
- 7) Loss due to voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Doctor.
- 8) Loss due to mental illness or nervous disorders without demonstrable organic disease (loss due to Parkinson's Disease, Alzheimer's Disease or senile dementia is covered).
- 9) Loss due to normal pregnancy and childbirth; Complications of Pregnancy, however, will be covered as a Sickness.

HOSPITAL INPATIENT OR AMBULATORY SURGICAL CENTER SURGICAL BENEFIT EXCLUSIONS

The following exclusions are in addition to the exclusions listed above. We will not pay benefits for:

- 1) Surgery for corns, calluses and bunions; deviated nasal septum, including submucous resection and/or other surgical corrections thereof unless due to Injury occurring while this Policy is in force.
- 2) Surgery for removal of breast implants. This exclusion shall not apply to the removal of breast implants for the treatment of a covered Injury/Accident or Sickness, unless the implants were implanted solely for cosmetic purposes and not for surgically performed reconstruction resulting from an Injury/Accident or Sickness.
- 3) Surgery for non-malignant warts, moles, boils and lesions unless deemed necessary by your Doctor.
- 4) Surgery for sex transformation or reversal thereof.
- 5) Dental surgery except oral surgery for excision of tumors, growths and cysts of the jaw and mouth and surgery to sound natural teeth made necessary by injury.

PRE-EXISTING CONDITIONS LIMITATION

Pre-Existing Condition: An Injury/Accident or Sickness, disclosed or not disclosed on the application, for which medical care, treatment, diagnosis or advice was received or recommended within the six (6) month period immediately prior to Your Effective Date of coverage under this Policy; or the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the six (6) months prior to Your Effective Date of coverage under this Policy. Treatment includes the taking of prescription drugs or medicines. Pre-Existing Conditions are not covered unless the loss begins more than six (6) months after Your Effective Date of coverage.

CLAIM PROVISIONS

NOTICE OF CLAIM: Written notice of claim must be sent to Us at Our Administrative Office within **thirty (30) days** after the start of a covered loss. The notice must include Your name and Policy number. If notice cannot reasonably be given within that time, You must send the notice as soon as possible.

PROOF OF LOSS: Written proof of loss must be furnished to Us within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time, provided proof is furnished as soon as is reasonably possible; and, in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. If You are legally incapable of submitting such proof, it may be submitted at any time that it is reasonably possible to do so.

CLAIM FORMS: We will send You claim forms when We receive written notice of claim. If forms are not received within twenty-one (21) days after written notice of claim is sent, then proof of claim will be met by giving Us a written statement of the type and the extent of the services. You must send such proof within the time limit stated above in the Proof of Loss provision.

PAYMENT OF CLAIMS: When We receive written proof of claim, We will pay any benefits due.

We will pay benefits to You, if living, or to Your estate. If benefits are payable to Your estate, We may pay up to \$1,000.00 to any relative of Yours whom We find is entitled to them. Any payment made in good faith will fully discharge Us to the extent of the payment.

TIME OF PAYMENT OF CLAIMS: Benefits payable under the Policy will be paid promptly following receipt of written Proof of Loss.

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

PHYSICAL EXAMINATIONS AND AUTOPSY: We have the right to have a Doctor of Our choice examine You as often as reasonably necessary while a claim is pending. Any such examinations will be made at Our expense. In the event of Your death, We may also have an autopsy made at Our expense unless prohibited by law.

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

CLAIM DENIAL: 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.

PREMIUMS

PREMIUM PAYMENTS: You are to pay each premium on or before its due date. A due date is the first day following the end of the period for which the preceding premium was paid. Premiums may be paid for twelve (12), six (6), or three (3) month periods. We will also accept monthly premiums when paid by electronic funds transfer, list bill, or when paid otherwise with Our prior approval.

GRACE PERIOD: We will grant a Grace Period of thirty-one (31) days for each premium payment after the first premium payment. Coverage remains in force during the Grace Period.

NOTICE OF LAPSE: We will provide You and any third party You have selected with notice of termination for non-payment of premium thirty (30) days after a premium is due. This notice shall be given by first class United States mail and will not be given until thirty (30) days after the premium is due and unpaid. Notice will be deemed to have been given as of seven (7) days after the date of mailing.

REINSTATEMENT: If a premium is not paid before the Grace Period ends, this Policy will lapse. Later acceptance of a premium by Us without asking for an application for Reinstatement, will reinstate this Policy as of 12:01 at Your residence on the day after the date We receive the premium.

If You are asked for an application, a conditional receipt for the premium will be given to You. If the application is approved, this Policy will be reinstated as of 12:01 at Your residence on the day after the date the Reinstatement application is approved. Lacking such approval, this Policy will be reinstated on the 45th day after the date of the receipt unless We write You of Our disapproval before that date.

The reinstated Policy will only cover a loss that results from an Injury/Accident sustained after the date of Reinstatement, or a Sickness that begins more than ten (10) days after such date. In all other respects, Your rights and Our rights will remain the same after You have satisfied 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 before the date of Reinstatement.

MISSTATEMENT OF AGE: If Your age has been misstated, the benefits may be adjusted, based on the relationship of the premium paid to the premium that should have been paid based on the correct age. If no insurance would have been available, We will refund the difference between the premiums You have paid less any benefits paid.

GENERAL PROVISIONS

THE CONTRACT: The entire contract includes:

- 1) this Policy;
- 2) any amendments to this Policy signed by any one of Our officers;
- 3) Your application for insurance under this Policy.

We consider any statement made by You, in the absence of fraud, to be a representation and not a warranty. No statement will be used to void the insurance, reduce benefits, or deny a claim unless:

- 1) the statement is in writing; and
- 2) a copy of that statement is given to You.

TIME LIMIT ON CERTAIN DEFENSES: We may void Your coverage or deny any claim for loss which starts within the first two (2) years of the Effective Date of Your coverage. We may do so only if We determine there was material misrepresentation that would have caused the application for this insurance to be declined. After two (2) years from the Effective Date of Your coverage only fraudulent misstatements in the application relating to Your health may be used to void Your coverage or deny any claim for loss that starts after the two (2) year period.

OTHER INSURANCE WITH US: If You are Insured with Us under more than one Policy of this type, only one Policy, to be chosen by You or Your estate, will be effective. The insurance under the other policies will be deemed to have ceased as of the date the duplication began. We will refund any premium paid to Us and not earned due to this clause. The refund will be based on the number of full months since the duplication began.

CONFORMITY WITH STATE LAWS: Any provision of this Policy which, on the Effective Date, is in conflict with the laws of the state in which it is delivered is amended to conform to the minimum requirements of such laws.

OUTLINE OF COVERAGE

Hospital Advantage Plus – A Hospital Confinement Indemnity Policy
Premiums May Be Changed By Class
Policy Form ELCHIP

EQUITABLE LIFE & CASUALTY INSURANCE COMPANY

Hospital Advantage Plus Administrative Office: P.O. Box 16958, Clearwater FL, 33766-6958
(855) 755-4663

KEEP THIS OUTLINE FOR YOUR RECORDS

THIS IS NOT A MEDICARE SUPPLEMENT POLICY

THIS IS A LIMITED BENEFIT POLICY - 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. Your policy sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you REVIEW YOUR POLICY CAREFULLY!

LIMITED BENEFIT COVERAGE

This policy is designed to provide, to the person insured, Limited Benefit Coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered Injury/Accident or Sickness, subject to any limitations set forth in the policy. Such policies do provide additional benefits other than the fixed daily benefit for hospital confinements, which are described below.

BENEFITS

The policy will only pay the following benefits:

1. Daily Hospital Indemnity Benefit
2. Ambulance Benefit
3. Emergency Room Benefit
4. Hospital Inpatient or ASC Surgical Benefit
5. Hospital Outpatient or ASC Laboratory & Radiology Benefit
6. Primary Care Physician Office Visit Benefit
7. Skilled Nursing Benefit
8. Welcome to Medicare Benefit
9. Annual Medicare Wellness Benefit
10. Additional Preventive Care Benefits

BENEFIT 1: DAILY HOSPITAL INDEMNITY BENEFIT

We will pay you the Daily Hospital Indemnity Benefit for each day you are Confined in a Hospital due to an Injury/Accident or Sickness. This benefit is payable up to 5 days per Calendar Year, and no more than a maximum of 200 days during your lifetime.

BENEFIT 2: AMBULANCE BENEFIT

We will pay you the Ambulance Benefit if a licensed surface or air ambulance service transports you to or from a Hospital where you are Confined as an inpatient due to an Injury/Accident or Sickness. Any ambulance service must be necessary to protect your health and safety when other reasonable and customary travel methods are not available. This benefit is payable up to 3 ambulance trips per Calendar Year.

BENEFIT 3: EMERGENCY ROOM BENEFIT

We will pay you the Emergency Room Benefit for services you receive in a Hospital emergency room or Hospital affiliated emergency care facility due to an Injury/Accident or Sickness, provided the Emergency treatment is followed within 24 hours by a Hospital Confinement. This benefit is payable up to 4 times per Calendar Year.

BENEFIT 4: HOSPITAL INPATIENT OR AMBULATORY SURGICAL CENTER (ASC) SURGICAL BENEFIT

We will pay you 10% of the scheduled benefit amount shown in the Medicare fee schedule for surgical procedures performed by a Doctor when the procedure is performed in a Hospital inpatient or Ambulatory Surgical Center setting, up to the Calendar Year maximum benefit amount shown in the benefit table below.

BENEFIT 5: HOSPITAL OUTPATIENT OR AMBULATORY SURGICAL CENTER (ASC) LABORATORY & RADIOLOGY BENEFIT

We will pay you the Hospital Outpatient or ASC Laboratory & Radiology Benefit for laboratory screenings and testing, x-rays or radiological tests received in an outpatient department of a Hospital or an Ambulatory Surgical Center (ASC), up to the Calendar Year maximum benefit amount shown in the benefit table below.

BENEFIT 6: PRIMARY CARE PHYSICIAN OFFICE VISIT BENEFIT

We will pay you the Primary Care Physician Office Visit Benefit for each office visit when you receive medical services from your Primary Care Physician, up to the maximum number of visits per Calendar Year shown in the benefit table below.

BENEFIT 7: SKILLED NURSING BENEFIT

We will pay you the daily Skilled Nursing Benefit when you are admitted to a Skilled Nursing Facility following a Hospital Confinement for which benefits were paid under the policy.

The benefit is only payable when:

- a) You have first been Hospital Confined for 3 or more consecutive days for which benefits are paid under the policy;
- b) The Skilled Nursing Facility confinement begins within 30 days after such Hospital Confinement;
- c) The Skilled Nursing Facility confinement is for the same Injury/Accident or Sickness as the Hospital Confinement; and
- d) Your Doctor certifies the need for the Skilled Nursing Facility confinement.

This benefit is payable for up to 20 days per Calendar Year.

BENEFIT 8: WELCOME TO MEDICARE BENEFIT

We will pay you the Welcome to Medicare Benefit for an initial preventive exam when you first become eligible for Medicare. The benefit is payable during the first 12 months of your Medicare Part B coverage when you visit your Primary Care Physician for your initial preventive exam.

BENEFIT 9: ANNUAL MEDICARE WELLNESS BENEFIT

We will pay you the Annual Medicare Wellness Benefit for one annual Medicare wellness visit to your Primary Care Physician. This benefit is payable once every 12 months after the first 12 months of your Medicare Part B coverage.

Payment of benefits for Primary Care Physician Office Visit (Benefit 6) and your Welcome to Medicare and/or Annual Medicare Wellness benefits (Benefits 8 & 9) cannot be combined during the same visit.

BENEFIT 10: ADDITIONAL PREVENTIVE CARE BENEFITS

We will pay the Additional Preventive Care Benefits when you complete any one of the following covered preventive care services:

- a) Mammogram
- b) Diabetes Screening
- c) Prostate Cancer Screening (PSA Test Only)
- d) Colorectal Cancer Screening
- e) Glaucoma Screening
- f) Pneumonia Vaccine
- g) Flu Vaccine
- h) Osteoporosis Testing
- i) Cervical & Vaginal Cancer Screening
- j) Cardiovascular Screening

The benefit is limited to a maximum of five (5) preventive screenings per Calendar Year.

BENEFIT LEVELS

	Policy Benefits	Maximum Per Calendar Year
Daily Hospital Indemnity Benefit	[\$100, \$125 or \$250] Per Day	5 Days
Ambulance Benefit	[\$75, \$100 or \$125] Per Trip	3 Trips
Emergency Room Benefit	[\$25 or \$50] Per Admission	4 Admissions
Hospital Inpatient or ASC Surgical Benefit	10% of Medicare Fee Schedule Amount	[\$500, \$1,000 or \$2,500]
Hospital Outpatient or ASC Laboratory & Radiology Benefit	[\$20, \$25 or \$30] Per Outpatient Visit	[\$500, \$700 or \$900]
Primary Care Physician Office Visit Benefit	[\$15, \$20 or \$25] Per Visit	[4,6 or 8] Visits
Skilled Nursing Benefit	[\$20, \$25 or \$60] Per Day	20 Days
Welcome to Medicare Benefit	\$25 For Initial Visit	1 Visit
Annual Medicare Wellness Benefit	\$25 For One Annual Visit	1 Visit
Additional Preventive Care Benefits	\$10 Per Completed Screening	5 Screenings

DEFINITIONS

AMBULATORY SURGICAL CENTER (ASC) means a medical facility designed and equipped to handle surgery, pain management, and certain diagnostic procedures that do not require overnight hospitalization. Most patients who are in relatively good health may receive treatment at ambulatory surgery centers. The centers may be part of a community general hospital, a specialty hospital, or an independent medical facility with prearranged hospital support. The centers are staffed with health professionals as in conventional surgery departments.

CALENDAR YEAR means the period beginning on the policy effective date and ending December 31 of that year. Thereafter it is the period from January 1 through December 31 of each following year.

COMPLICATIONS OF PREGNANCY means any condition that requires medical treatment or Hospital Confinement prior to or subsequent to the termination of the pregnancy whose diagnosis is distinct from, but is adversely affected by the pregnancy. Such conditions include, but are not limited to: (1) acute nephritis; (2) nephrosis; (3) cardiac decompensation; (4) missed abortion; and, (5) similar conditions of comparable severity. A complication of pregnancy will also include nonelective cesarean section or termination of pregnancy that occurs during a period of gestation when a viable birth is possible. "Complications of Pregnancy" will not include: (1) false labor; (2) occasional spotting; (3) prescribed bed rest; (4) morning Sickness; or, (5) similar conditions that are common to the care of a difficult pregnancy.

DAILY HOSPITAL BENEFIT AMOUNT means the amount we will pay each day when Hospital Confined.

DOCTOR means any licensed practitioner of the healing arts operating within the scope of his or her license in treating any Injury or Sickness. It doesn't include a member of Your Immediate Family.

EMERGENCY ROOM means a hospital room or area staffed and equipped for the reception and treatment of persons with conditions (as illness or trauma) requiring immediate medical care.

HOSPITAL means an institution which operates pursuant to law that has organized facilities for the care and treatment of sick and injured persons on a resident or inpatient basis, including facilities for diagnosis and surgery under the supervision of a staff of one (1) or more Doctors and which provides 24 hour nursing services by registered nurses on duty or call. Hospital does not mean convalescent, nursing, rest or extended care facilities or facilities operated exclusively for treatment of the aged, drug addicts or alcoholics, even though such facilities are operated as a separate institution by a Hospital.

HOSPITAL CONFINEMENT/CONFINED means confinement in a Hospital as a resident bed patient for a period of 24 consecutive hours or longer. Observation days are not considered to be Hospital Confined and will not be payable.

IMMEDIATE FAMILY means a person that is related to you by blood, marriage or adoption, including, but not limited to, you or your spouse, your or your spouse's parents, your or your spouse's grandparents, your or your spouse's children, your or your spouse's grandchildren, or your or your spouse's siblings.

INJURY/ACCIDENT means an accidental bodily injury sustained by you that is the direct cause of loss, independent of disease or bodily infirmity. The loss must begin while your insurance under the policy is in force.

MAXIMUM PER CALENDAR YEAR means the maximum amount We will pay each Calendar Year for covered services. The Maximum per calendar year is shown in the benefit table above.

PRIMARY CARE PHYSICIAN means a Doctor, such as a family practitioner or internist who is chosen by an individual to provide continuous medical care, trained to treat a wide variety of health-related problems, and one who usually is the first health professional to examine a patient and who recommends secondary care physicians. A Primary Care Physician is not a medical or surgical specialist or a member of Your Immediate Family.

SICKNESS means an illness or a disease that results in loss covered by the policy. The loss must begin while the policy is in force.

LIMITATIONS AND EXCLUSIONS

PRE-EXISTING CONDITIONS LIMITATION

Pre-Existing Condition: An Injury/Accident or Sickness, disclosed or not disclosed on the application, for which medical care, treatment, diagnosis or advice was received or recommended within the 6 month period immediately prior to your effective date of coverage under the policy; or the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 6 months prior to your effective date of coverage under the policy. Treatment includes the taking of prescription drugs or medicines. Pre-Existing Conditions are not covered unless the loss begins more than 6 months after your effective date of coverage.

EXCLUSIONS

We will not pay benefits for:

- 1) Treatment, services or supplies which:
 - a) Are not prescribed by a Doctor as necessary to treat an Injury/Accident or Sickness;
 - b) Are received without charge or legal obligation to pay;
 - c) Would not routinely be paid in the absence of insurance;
 - d) Are received from any member of Your Immediate Family;
 - e) Are received outside the United States; or
 - f) Are incurred while the policy is not in force.
- 2) Expenses incurred as a result of loss due to war, or any action of war, declared or undeclared; service in the armed forces of any country.
- 3) Expenses incurred as a result of committing or attempting to commit an assault or felony or participating in a riot or civil commotion.
- 4) Expenses incurred as a result of suicide or intentionally self-inflicted injury while sane.
- 5) Cosmetic surgery other than:
 - a) Reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or
 - b) Reconstructive surgery because of a congenital disease or anomaly.
- 6) Injury/Accident due to being legally intoxicated, as defined by the jurisdiction in which an Injury/Accident occurs.
- 7) Loss due to voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Doctor.
- 8) Loss due to mental illness or nervous disorders without demonstrable organic disease (loss due to Parkinson's Disease, Alzheimer's Disease or senile dementia is covered).
- 9) Loss due to normal pregnancy and childbirth; Complications of Pregnancy, however, will be covered as a Sickness.

HOSPITAL INPATIENT OR AMBULATORY SURGICAL CENTER SURGICAL BENEFIT EXCLUSIONS

The following exclusions are in addition to the exclusions listed above. We will not pay benefits for:

- 1) Surgery for corns, calluses and bunions; deviated nasal septum, including submucous resection and/or other surgical corrections thereof unless due to Injury occurring while the policy is in force.
- 2) Surgery for removal of breast implants. This exclusion shall not apply to the removal of breast implants for the treatment of a covered Injury/Accident or Sickness, unless the implants were implanted solely for cosmetic purposes and not for surgically performed reconstruction resulting from an Injury/Accident or Sickness.
- 3) Surgery for non-malignant warts, moles, boils and lesions unless deemed necessary by your Doctor.
- 4) Surgery for sex transformation or reversal thereof.
- 5) Dental surgery except oral surgery for excision of tumors, growths and cysts of the jaw and mouth and surgery to sound natural teeth made necessary by Injury/Accident.

GUARANTEED RENEWABLE FOR LIFE

Your policy will stay in force by paying the renewal premium at the intervals available to you at time of renewal. You must pay the renewal premium by its due date or during the 31 days that follow. We cannot cancel or refuse to renew the policy or place any restrictions on it if you pay your premiums on time.

REINSTATEMENT

Reinstatements may be made within 60 days of the due date of the premium in default. Payment of back premiums with satisfactory evidence of insurability is required.

PREMIUMS SUBJECT TO CHANGE

We will not change the premium for the policy during your first year of coverage. Thereafter, we may change the premium rates for the policy by giving you at least 31 days prior written notice of any change in the renewal premium. We can only change the premium if we change it for all policies like yours in your state on a class basis.

INITIAL PREMIUM

Hospital Confinement Indemnity Policy: \$ _____

APPLICATION

Hospital Advantage Plus – A Hospital Confinement Indemnity Policy

Equitable Life & Casualty Insurance Company

Hospital Advantage Plus Administrative Office: P.O. Box 16958, Clearwater, FL 33766-6958

Phone: (855) 775-4663 • Fax: (855) 367-0114

APPLICATION FOR: New Coverage Reinstatement Change of Benefits

If reinstatement or change of benefits requested, please print policy number affected: _____

MAIL POLICY TO: Agent Insured

Part A. Applicant Information

_____			<input type="checkbox"/> Male	<input type="checkbox"/> Female
Last Name	First Name	MI		

Soc. Sec. #	Birth Date (mm/dd/yyyy)	Age		

Street Address	City	State	Zip	

Daytime Phone (please include area code)	Best Time to Call	E-Mail Address		

QUALIFYING INFORMATION

(If any answer to questions 1 thru 5 is "YES" you are **not** eligible for coverage. DO NOT SUBMIT APPLICATION.)

1. In the past 12 months have you: been confined as an inpatient to a hospital or a nursing home or have you received home health care?..... YES NO
2. In the past 24 months have you: had a heart attack, stroke, congestive heart failure, heart surgery/bypass, malignant melanoma or cancer (other than skin cancer)? YES NO
3. In the past 12 months have you: been treated for chronic obstructive lung disease, insulin dependent diabetes, dementia, Alzheimer's disease, cirrhosis, diabetes with complications or chronic liver or kidney disease; been prescribed to use oxygen?..... YES NO
4. In the past 12 months have you: had surgery which required an inpatient hospital stay or been advised to have surgery which will require an inpatient stay but have not yet done so? YES NO
5. Have you ever: been treated for or been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or HIV infection, aneurysm, cardiomyopathy, or peripheral vascular disease; been treated for drug or alcohol abuse; received an organ transplant, had an amputation due to disease, or used a defibrillator? YES NO

Plan Selection A B C

Will this policy replace any existing insurance with any company? YES NO
If yes, please complete the Replacement Notice.

PART B. PREMIUM

Hospital Confinement Indemnity Annual Premium for Applicant \$ _____

Premium Payment Mode Annual Semi-Annual (.52)
 Quarterly (.265) Monthly EFT (1/12)

Total Mode Premium for Applicant \$ _____

Total Initial Premium + one-time \$25 Application Fee \$ _____

Requested Effective Date ____ / ____ / ____

Requested Effective Date cannot be prior to the Application Date.
If no Effective Date is requested, the Effective Date will be the date of the underwriting decision to approve issuance coverage.

PART C. MONTHLY PRE-AUTHORIZED PREMIUM PAYMENT PLAN

Authorization to Honor Withdrawals to be drawn by Equitable Life & Casualty Insurance Company.

TO _____
Name of my Bank My Bank's Address City State Zip Code

As a convenience to me, I request and authorize you to charge the account shown below for premiums drawn by and payable to the order of Equitable Life & Casualty Insurance Company, Salt Lake City, Utah, provided there are sufficient funds in my account to pay the same upon presentation.

Account # _____ Bank Routing # _____

Account Type: Checking Account Savings Account Bank Draft Day (days 1-28) _____
(Attach a Voided "Sample" check if applicable, or a Deposit slip)

I agree that my rights in respect to each payment shall be the same as if it were drawn by me and signed personally by me. This authority is to remain in effect until revoked by me in writing and until you receive notice for which you agree you will be fully protected in honoring such requests. I further agree that if any such payment is not honored, whether with or without cause and whether intentionally, or inadvertently, you shall be under no liability at all although such action could result in the forfeiture of insurance.

X _____
Premium Payer's Signature (as it appears on bank records) Printed Name of Insured (if different from premium payer)

PART D. NOTICE OF LAPSE

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

I elect NOT to designate a third party designee. I elect to designate an third party designee, named below.

Last Name First Name MI Phone (please include area code)

Street Address City State Zip

