Equitable National Application Packet

Thank you for your interest in the Equitable National Life Medicare Supplement plan!

This application packet provides you with access to a printable copy of the Enrollment Form and the Outline of Coverage in addition to a link to the Choosing a Medigap Policy Guide.

Should you decide to apply by secure upload/mail/fax/email, the printable application needs to be reviewed and signed by an Agent before it can be submitted to Equitable Life. You may email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: cs@cda-insurance.com
- Secure File Upload: Click here
- Mail: CDA Insurance LLC
  PO Box 26540
  Eugene, Oregon 97402

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf) Download Coverage Outline (.pdf) Download Application (.pdf)

Our website: https://www.medicare-texas.net

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.

Outline of Medicare Supplement Plans A, F, G, N

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

Basic Benefits:

Hospitalization - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end;

Medical Expenses - Part B coinsurance (generally 20% of Medicare-approved expenses) or co-payments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of the part B coinsurance or co-payments;

Blood - First three pints of blood each year;

Hospice - Part A coinsurance.

A❖	B	C	D	F❖ F*	G❖	K	L	M	N❖
Basic Including 100% Part B coinsurance	Basic Including 100% Part B coinsurance	Basic Including 100% Part B coinsurance	Basic Including 100% Part B coinsurance	Basic Including 100% Part B coinsurance	Basic Including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 co-payment for office visits and up to $50 co-payment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-Pocket limit $5120; paid at 100% after limit reached	Out-of-Pocket limit $2560; paid at 100% after limit reached		

❖Plans currently available for sale.

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2200 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2200. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Premiums - Monthly Bank Draft
Non-Tobacco
Area 1 - Zip Codes: 733, 739, 754-759, 762-769, 778-781, 783, 785-792, 795-799, 885
A one-time $20 policy fee applies to each application

	Plan A		Plan F		Plan G		Plan N	
Age	Male	Female	Male	Female	Male	Female	Male	Female
0-64	428.97	373.02						
65	107.24	93.25	138.32	120.28	108.32	94.20	91.36	79.44
66	107.24	93.25	138.32	120.28	108.32	94.20	91.36	79.44
67	107.24	93.25	138.32	120.28	108.32	94.20	91.36	79.44
68	108.64	94.47	139.40	121.22	109.74	95.43	92.48	80.42
69	112.13	97.51	143.18	124.51	113.26	98.49	95.31	82.88
70	115.21	100.18	146.49	127.38	116.37	101.19	97.84	85.07
71	119.38	103.81	151.23	131.50	120.59	104.86	101.43	88.20
72	123.55	107.44	155.96	135.62	124.80	108.52	105.02	91.33
73	128.37	111.62	161.50	140.43	129.66	112.75	109.16	94.92
74	132.56	115.27	166.25	144.57	133.90	116.43	112.78	98.07
75	138.38	120.33	173.58	150.94	140.21	121.92	118.13	102.73
76	142.73	124.11	180.21	156.70	145.86	126.83	123.10	107.04
77	147.19	127.99	187.03	162.63	151.67	131.88	128.19	111.47
78	151.77	131.97	194.03	168.72	157.64	137.07	133.44	116.03
79	156.46	136.05	201.22	174.98	163.77	142.41	138.83	120.72
80	161.27	140.24	208.62	181.40	170.08	147.89	144.37	125.54
81	165.59	143.99	216.17	187.97	176.52	153.49	150.23	130.63
82	170.01	147.83	223.92	194.71	183.14	159.25	156.24	135.86
83	174.53	151.77	231.88	201.64	189.94	165.16	162.43	141.24
84	179.16	155.79	240.06	208.75	196.92	171.24	168.79	146.77
85	183.99	160.00	248.58	216.16	204.20	177.56	175.41	152.53
86	188.18	163.64	256.19	222.78	210.66	183.18	181.30	157.65
87	192.46	167.36	264.00	229.56	217.29	188.94	187.35	162.91
88	196.83	171.16	272.01	236.53	224.09	194.86	193.56	168.31
89	201.30	175.05	280.22	243.67	231.07	200.93	199.93	173.86
90	205.87	179.02	288.65	251.00	238.23	207.16	206.48	179.55
91	209.89	182.51	296.61	257.93	244.98	213.02	212.71	184.97
92	213.98	186.07	304.78	265.02	251.89	219.04	219.11	190.53
93	218.16	189.70	313.14	272.30	258.98	225.20	225.67	196.23
94	222.41	193.40	321.71	279.75	266.25	231.52	232.39	202.08
95	226.75	197.17	330.49	287.38	273.69	237.99	239.29	208.08
96	230.94	200.82	336.61	292.70	278.75	242.39	243.72	211.93
97	235.22	204.54	342.83	298.12	283.91	246.88	248.23	215.85
98	239.57	208.32	349.18	303.63	289.16	251.44	252.82	219.84
99	244.00	212.17	355.63	309.25	294.51	256.10	257.49	223.91

Household Discount Available to those who qualify.

Premiums - Monthly Bank Draft
Tobacco
Area 1 - Zip Codes: 733, 739, 754-759, 762-769, 778-781, 783, 785-792, 795-799, 885
A one-time $20 policy fee applies to each application

	Plan A		Plan F		Plan G		Plan N	
Age	Male	Female	Male	Female	Male	Female	Male	Female
0-64	493.31	428.97						
65	123.33	107.24	159.06	138.32	124.57	108.32	105.06	91.36
66	123.33	107.24	159.06	138.32	124.57	108.32	105.06	91.36
67	123.33	107.24	159.06	138.32	124.57	108.32	105.06	91.36
68	124.94	108.64	160.32	139.40	126.20	109.74	106.36	92.48
69	128.95	112.13	164.66	143.18	130.25	113.26	109.60	95.31
70	132.49	115.21	168.47	146.49	133.82	116.37	112.51	97.84
71	137.29	119.38	173.91	151.23	138.67	120.59	116.65	101.43
72	142.09	123.55	179.35	155.96	143.52	124.80	120.78	105.02
73	147.62	128.37	185.72	161.50	149.11	129.66	125.54	109.16
74	152.44	132.56	191.19	166.25	153.98	133.90	129.69	112.78
75	159.14	138.38	199.61	173.58	161.24	140.21	135.85	118.13
76	164.14	142.73	207.24	180.21	167.74	145.86	141.56	123.10
77	169.27	147.19	215.08	187.03	174.42	151.67	147.42	128.19
78	174.53	151.77	223.13	194.03	181.28	157.64	153.46	133.44
79	179.93	156.46	231.41	201.22	188.34	163.77	159.66	138.83
80	185.47	161.27	239.91	208.62	195.59	170.08	166.03	144.37
81	190.43	165.59	248.59	216.17	202.99	176.52	172.76	150.23
82	195.51	170.01	257.51	223.92	210.61	183.14	179.68	156.24
83	200.71	174.53	266.67	231.88	218.43	189.94	186.79	162.43
84	206.04	179.16	276.07	240.06	226.46	196.92	194.11	168.79
85	211.59	183.99	285.87	248.58	234.83	204.20	201.72	175.41
86	216.41	188.18	294.62	256.19	242.25	210.66	208.49	181.30
87	221.33	192.46	303.60	264.00	249.88	217.29	215.45	187.35
88	226.36	196.83	312.81	272.01	257.70	224.09	222.59	193.56
89	231.50	201.30	322.25	280.22	265.73	231.07	229.92	199.93
90	236.75	205.87	331.94	288.65	273.96	238.23	237.45	206.48
91	241.37	209.89	341.11	296.61	281.72	244.98	244.62	212.71
92	246.08	213.98	350.49	304.78	289.68	251.89	251.97	219.11
93	250.88	218.16	360.11	313.14	297.83	258.98	259.52	225.67
94	255.77	222.41	369.97	321.71	306.18	266.25	267.25	232.39
95	260.76	226.75	380.06	330.49	314.74	273.69	275.18	239.29
96	265.59	230.94	387.10	336.61	320.56	278.75	280.27	243.72
97	270.50	235.22	394.26	342.83	326.50	283.91	285.46	248.23
98	275.50	239.57	401.55	349.18	332.54	289.16	290.74	252.82
99	280.60	244.00	408.98	355.63	338.69	294.51	296.12	257.49

Household Discount Available to those who qualify.

Premiums - Monthly Bank Draft
Non-Tobacco
Area 2 - Zip Codes: 750-753, 760-761, 774, 776-777, 782, 784, 793-794
A one-time $20 policy fee applies to each application

	Plan A		Plan F		Plan G		Plan N	
Age	Male	Female	Male	Female	Male	Female	Male	Female
0-64	483.21	420.18						
65	120.80	105.04	155.80	135.48	122.02	106.11	102.91	89.49
66	120.80	105.04	155.80	135.48	122.02	106.11	102.91	89.49
67	120.80	105.04	155.80	135.48	122.02	106.11	102.91	89.49
68	122.38	106.42	157.03	136.55	123.62	107.49	104.18	90.59
69	126.31	109.83	161.29	140.25	127.58	110.94	107.36	93.36
70	129.77	112.84	165.01	143.49	131.08	113.98	110.21	95.83
71	134.47	116.93	170.35	148.13	135.83	118.11	114.26	99.35
72	139.18	121.02	175.68	152.76	140.58	122.24	118.30	102.87
73	144.60	125.74	181.92	158.19	146.06	127.01	122.97	106.93
74	149.32	129.84	187.28	162.85	150.83	131.16	127.03	110.47
75	155.88	135.54	195.52	170.02	157.94	137.34	133.07	115.71
76	160.78	139.80	203.00	176.52	164.30	142.87	138.66	120.57
77	165.80	144.18	210.67	183.19	170.84	148.56	144.40	125.57
78	170.96	148.66	218.56	190.05	177.57	154.41	150.31	130.71
79	176.24	153.26	226.67	197.10	184.48	160.41	156.38	135.99
80	181.67	157.97	234.99	204.34	191.58	166.59	162.63	141.42
81	186.53	162.20	243.50	211.74	198.84	172.90	169.22	147.15
82	191.50	166.52	252.23	219.33	206.29	179.38	176.00	153.04
83	196.60	170.95	261.20	227.13	213.95	186.04	182.97	159.10
84	201.81	175.49	270.42	235.14	221.82	192.89	190.13	165.33
85	207.26	180.22	280.01	243.49	230.01	200.01	197.58	171.81
86	211.97	184.33	288.58	250.94	237.29	206.34	204.22	177.58
87	216.80	188.52	297.38	258.59	244.76	212.83	211.03	183.51
88	221.72	192.80	306.40	266.43	252.42	219.50	218.03	189.59
89	226.76	197.18	315.65	274.48	260.28	226.33	225.21	195.84
90	231.90	201.65	325.14	282.73	268.35	233.35	232.59	202.25
91	236.42	205.59	334.12	290.54	275.95	239.96	239.61	208.36
92	241.04	209.60	343.31	298.53	283.74	246.73	246.81	214.62
93	245.74	213.69	352.73	306.73	291.72	253.67	254.20	221.04
94	250.53	217.86	362.39	315.12	299.91	260.79	261.78	227.63
95	255.42	222.10	372.28	323.72	308.29	268.08	269.55	234.39
96	260.15	226.21	379.16	329.71	314.00	273.04	274.53	238.72
97	264.96	230.40	386.18	335.81	319.81	278.09	279.61	243.14
98	269.86	234.66	393.32	342.02	325.72	283.24	284.78	247.64
99	274.85	239.00	400.60	348.35	331.75	288.48	290.05	252.22

Household Discount Available to those who qualify.

Premiums - Monthly Bank Draft
Tobacco
Area 2 - Zip Codes: 750-753, 760-761, 774, 776-777, 782, 784, 793-794
A one-time $20 policy fee applies to each application

	Plan A		Plan F		Plan G		Plan N	
Age	Male	Female	Male	Female	Male	Female	Male	Female
0-64	555.69	483.21						
65	138.92	120.80	179.18	155.80	140.32	122.02	118.35	102.91
66	138.92	120.80	179.18	155.80	140.32	122.02	118.35	102.91
67	138.92	120.80	179.18	155.80	140.32	122.02	118.35	102.91
68	140.74	122.38	180.58	157.03	142.16	123.62	119.80	104.18
69	145.26	126.31	185.48	161.29	146.72	127.58	123.46	107.36
70	149.24	129.77	189.77	165.01	150.74	131.08	126.74	110.21
71	154.64	134.47	195.90	170.35	156.21	135.83	131.39	114.26
72	160.05	139.18	202.03	175.68	161.67	140.58	136.05	118.30
73	166.29	144.60	209.20	181.92	167.96	146.06	141.41	122.97
74	171.72	149.32	215.37	187.28	173.45	150.83	146.09	127.03
75	179.26	155.88	224.85	195.52	181.63	157.94	153.03	133.07
76	184.89	160.78	233.44	203.00	188.95	164.30	159.46	138.66
77	190.67	165.80	242.27	210.67	196.47	170.84	166.06	144.40
78	196.60	170.96	251.35	218.56	204.20	177.57	172.86	150.31
79	202.68	176.24	260.67	226.67	212.15	184.48	179.84	156.38
80	208.92	181.67	270.24	234.99	220.32	191.58	187.02	162.63
81	214.51	186.53	280.02	243.50	228.66	198.84	194.60	169.22
82	220.23	191.50	290.07	252.23	237.23	206.29	202.40	176.00
83	226.09	196.60	300.38	261.20	246.04	213.95	210.41	182.97
84	232.09	201.81	310.98	270.42	255.09	221.82	218.65	190.13
85	238.35	207.26	322.01	280.01	264.52	230.01	227.22	197.58
86	243.77	211.97	331.87	288.58	272.88	237.29	234.85	204.22
87	249.31	216.80	341.99	297.38	281.47	244.76	242.69	211.03
88	254.98	221.72	352.36	306.40	290.28	252.42	250.73	218.03
89	260.77	226.76	363.00	315.65	299.33	260.28	259.00	225.21
90	266.69	231.90	373.91	325.14	308.60	268.35	267.48	232.59
91	271.89	236.42	384.23	334.12	317.34	275.95	275.55	239.61
92	277.19	241.04	394.81	343.31	326.30	283.74	283.83	246.81
93	282.60	245.74	405.64	352.73	335.48	291.72	292.33	254.20
94	288.11	250.53	416.75	362.39	344.89	299.91	301.04	261.78
95	293.73	255.42	428.12	372.28	354.54	308.29	309.98	269.55
96	299.17	260.15	436.04	379.16	361.10	314.00	315.71	274.53
97	304.70	264.96	444.11	386.18	367.78	319.81	321.55	279.61
98	310.34	269.86	452.32	393.32	374.58	325.72	327.50	284.78
99	316.08	274.85	460.69	400.60	381.51	331.75	333.56	290.05

Household Discount Available to those who qualify.

Premiums - Monthly Bank Draft
Non-Tobacco
Area 3 - Zip Codes: 770-773, 775
A one-time $20 policy fee applies to each application

	Plan A		Plan F		Plan G		Plan N	
Age	Male	Female	Male	Female	Male	Female	Male	Female
0-64	542.37	471.63						
65	135.59	117.91	174.88	152.07	136.96	119.10	115.51	100.45
66	135.59	117.91	174.88	152.07	136.96	119.10	115.51	100.45
67	135.59	117.91	174.88	152.07	136.96	119.10	115.51	100.45
68	137.36	119.45	176.26	153.27	138.75	120.65	116.93	101.68
69	141.78	123.28	181.04	157.42	143.21	124.53	120.51	104.79
70	145.66	126.66	185.22	161.06	147.13	127.94	123.70	107.57
71	150.94	131.25	191.21	166.27	152.46	132.58	128.25	111.52
72	156.22	135.84	197.19	171.47	157.80	137.21	132.79	115.47
73	162.30	141.13	204.19	177.56	163.94	142.56	138.02	120.02
74	167.61	145.74	210.21	182.79	169.30	147.22	142.59	123.99
75	174.96	152.14	219.46	190.84	177.28	154.15	149.37	129.88
76	180.46	156.92	227.85	198.13	184.42	160.36	155.64	135.34
77	186.10	161.83	236.47	205.63	191.76	166.75	162.09	140.94
78	191.89	166.86	245.32	213.33	199.31	173.31	168.72	146.71
79	197.82	172.02	254.42	221.24	207.07	180.06	175.53	152.64
80	203.91	177.31	263.77	229.36	215.04	186.99	182.54	158.73
81	209.37	182.06	273.31	237.66	223.18	194.07	189.94	165.17
82	214.95	186.92	283.12	246.19	231.55	201.35	197.55	171.78
83	220.67	191.89	293.19	254.94	240.15	208.82	205.37	178.58
84	226.53	196.98	303.53	263.94	248.98	216.50	213.41	185.57
85	232.64	202.29	314.30	273.30	258.18	224.50	221.78	192.85
86	237.93	206.90	323.92	281.67	266.35	231.61	229.23	199.33
87	243.34	211.60	333.79	290.25	274.73	238.89	236.88	205.98
88	248.87	216.41	343.92	299.06	283.33	246.37	244.73	212.81
89	254.52	221.32	354.30	308.09	292.15	254.05	252.79	219.82
90	260.30	226.34	364.95	317.35	301.21	261.92	261.07	227.02
91	265.37	230.76	375.03	326.11	309.74	269.34	268.95	233.87
92	270.55	235.26	385.35	335.09	318.48	276.94	277.03	240.90
93	275.83	239.85	395.93	344.28	327.45	284.74	285.33	248.11
94	281.21	244.53	406.76	353.71	336.63	292.72	293.83	255.50
95	286.70	249.30	417.86	363.36	346.04	300.91	302.55	263.09
96	292.00	253.91	425.59	370.08	352.45	306.47	308.15	267.95
97	297.40	258.61	433.47	376.93	358.96	312.14	313.85	272.91
98	302.90	263.39	441.49	383.90	365.61	317.92	319.65	277.96
99	308.51	268.27	449.65	391.00	372.37	323.80	325.57	283.10

Household Discount Available to those who qualify.

Premiums - Monthly Bank Draft
Tobacco
Area 3 - Zip Codes: 770-773, 775
A one-time $20 policy fee applies to each application

	Plan A		Plan F		Plan G		Plan N	
Age	Male	Female	Male	Female	Male	Female	Male	Female
0-64	623.73	542.37						
65	155.93	135.59	201.12	174.88	157.51	136.96	132.84	115.51
66	155.93	135.59	201.12	174.88	157.51	136.96	132.84	115.51
67	155.93	135.59	201.12	174.88	157.51	136.96	132.84	115.51
68	157.97	137.36	202.70	176.26	159.57	138.75	134.47	116.93
69	163.04	141.78	208.19	181.04	164.69	143.21	138.58	120.51
70	167.51	145.66	213.00	185.22	169.20	147.13	142.26	123.70
71	173.58	150.94	219.89	191.21	175.33	152.46	147.48	128.25
72	179.65	156.22	226.77	197.19	181.46	157.80	152.71	132.79
73	186.65	162.30	234.82	204.19	188.53	163.94	158.73	138.02
74	192.75	167.61	241.74	210.21	194.69	169.30	163.98	142.59
75	201.21	174.96	252.38	219.46	203.87	177.28	171.77	149.37
76	207.53	180.46	262.03	227.85	212.08	184.42	178.98	155.64
77	214.02	186.10	271.94	236.47	220.53	191.76	186.40	162.09
78	220.67	191.89	282.12	245.32	229.20	199.31	194.02	168.72
79	227.50	197.82	292.58	254.42	238.13	207.07	201.86	175.53
80	234.50	203.91	303.33	263.77	247.29	215.04	209.92	182.54
81	240.77	209.37	314.31	273.31	256.66	223.18	218.43	189.94
82	247.20	214.95	325.59	283.12	266.28	231.55	227.18	197.55
83	253.77	220.67	337.16	293.19	276.17	240.15	236.18	205.37
84	260.51	226.53	349.06	303.53	286.33	248.98	245.42	213.41
85	267.53	232.64	361.44	314.30	296.91	258.18	255.05	221.78
86	273.62	237.93	372.51	323.92	306.30	266.35	263.61	229.23
87	279.84	243.34	383.86	333.79	315.94	274.73	272.41	236.88
88	286.20	248.87	395.51	343.92	325.83	283.33	281.44	244.73
89	292.70	254.52	407.45	354.30	335.98	292.15	290.71	252.79
90	299.34	260.30	419.70	364.95	346.39	301.21	300.23	261.07
91	305.18	265.37	431.28	375.03	356.20	309.74	309.29	268.95
92	311.13	270.55	443.15	385.35	366.26	318.48	318.59	277.03
93	317.20	275.83	455.32	395.93	376.56	327.45	328.13	285.33
94	323.39	281.21	467.78	406.76	387.13	336.63	337.90	293.83
95	329.70	286.70	480.54	417.86	397.95	346.04	347.93	302.55
96	335.80	292.00	489.43	425.59	405.31	352.45	354.37	308.15
97	342.01	297.40	498.49	433.47	412.81	358.96	360.93	313.85
98	348.34	302.90	507.71	441.49	420.45	365.61	367.60	319.65
99	354.78	308.51	517.10	449.65	428.23	372.37	374.40	325.57

Household Discount Available to those who qualify.

PREMIUM INFORMATION
We, Equitable National, can only raise your premium if we raise the premium for all policies like yours in this State. We will not change the premiums for this policy during your first year of coverage. Thereafter your premium will increase each year based on your age at that time. No rate adjustment may be made on an individual basis. Also, your renewal premiums may change on a renewal date following the Effective Date of any change in the deductible and/or coinsurance amounts which you are required to pay under Medicare. Any such premium change will be based on the actuarial computations that we then use to determine the renewal premium.

HOUSEHOLD PREMIUM DISCOUNT
If you resided with at least one, but no more than three, other adults who are age 18 or older for the past year, you will be eligible for a household premium discount. The discounted premium will be priced 7% lower than the rates illustrated. Your policy's household premium discount will be removed and your premium will increase if the other adult no longer resides with you (other than in the case of his or her death).

DISCLOSURES
Use this outline to compare benefits and premiums among policies, certificates and contracts.

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

RIGHT TO RETURN POLICY
If you find that you are not satisfied with your policy, you may return it to us at: PO Box 2730, Salt Lake City, Utah 84110-2730. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued, and return all of your payments.

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

NOTICE
This policy may not fully cover all of your medical costs. Neither Equitable National nor its producers are connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "The Medicare Handbook" for more details.

LIMITATIONS & EXCLUSIONS
We will not pay benefits for (a) Expenses incurred while coverage is not in force except as provided in the Extension of Benefits section; (b) Hospital or Skilled Nursing Facility charges incurred prior to effective date of Policy; (c) That portion of any expense incurred which is paid for by Medicare; (d) Services for non-Medicare Eligible Expenses unless specifically covered under this Policy, including, but not limited to, routine exams, take-home drugs and eye refractions; or (e) Services for which a charge is not normally made in the absence of insurance.

REFUND OF PREMIUMS
In the event of cancellation or death, we will promptly return the pro rata unearned portion of any premium paid.

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

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

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

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1316	$0	$1316 (Part A deductible)
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after -While using 60 lifetime reserve days	All but $658 a day	$658 a day	$0
Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $164.50 a day	$0	Up to $164.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

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

PLAN A (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

** *Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $183 of Medicare Approved Amounts **	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $183 of Medicare Approved Amounts**	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES -			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Part A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment First $183 of Medicare Approved Amounts**	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

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

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1316	$1316 (Part A deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after -While using 60 lifetime reserve days	All but $658 a day	$658 a day	$0
Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $164.50 a day	Up to $164.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

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

PLAN F (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

** *Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $183 of Medicare Approved Amounts **	$0	$183 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $183 of Medicare Approved Amounts**	$0	$183 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES -			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Part A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $183 of Medicare Approved Amounts**	$0	$183 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

Other Benefits - Not Covered by Medicare

FOREIGN TRAVEL - NOT COVERED BY MEDICARE, Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1316	$1316 (Part A deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after -While using 60 lifetime reserve days	All but $658 a day	$658 a day	$0
Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $164.50 a day	Up to $164.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

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

PLAN G (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

** *Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $183 of Medicare Approved Amounts **	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $183 of Medicare Approved Amounts**	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES -			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Part A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $183 of Medicare Approved Amounts**	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

Other Benefits - Not Covered by Medicare

FOREIGN TRAVEL - NOT COVERED BY MEDICARE, Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1316	$1316 (Part A deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after -While using 60 lifetime reserve days	All but $658 a day	$658 a day	$0
Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $164.50 a day	Up to $164.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

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

PLAN N (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

** *Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $183 of Medicare Approved Amounts **	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $183 of Medicare Approved Amounts**	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
Part A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment	100%	$0	$0
First $183 of Medicare Approved Amounts**	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Other Benefits - Not Covered by Medicare			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE, Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Premium Calculation

Medicare Supplement Plan _____

	Steps	**Example -** *Information displayed is for illustrational purposes only*	Enrollee
#1	**Enrollee Age** **Enrollee Zip Code**	65 12345	
#2	**Premium** Premium shown in Outline of Coverage	$150.00	
#3	**Household Premium Discount** Rules shown in Application and Underwriting Guide; Multiply premium by .93 which equals a 7% discount	$150.00 x .93 = $139.50	
#4	**Payment Options** Modal Premiums – To determine other pay schedules, multiply the monthly premium by: Annual = MBD x 12 Semi-Annual = MBD x 6 Quarterly= MBD x 3	Example only: Annual: $139.50 x 12 =$1674.00 Semi-Annual: $139.50 x 6 =$837.00 Quarterly: $139.50 x3 = $418.50	

NOTICE OF OUR INFORMATION PRACTICES AND PRIVACY POLICY

With your application for insurance we receive personal information about you. You also authorized us to collect your health information. We keep and protect all such information as confidential and do not disclose it to any other persons, entities or organizations unless authorized by you in writing or as allowed or required by law.

Information We Collect And Receive
Personal information we receive about you comes directly from you, such as your name, address, birth date, Social Security number, telephone number, or e-mail address. Health (medical) information about you comes from you and your health care providers (doctors, clinics, hospitals, laboratories, etc.) based on your written Authorization. We may also review information about you on file with the MIB Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members.

What We Do With This Information
Your personal information is entered in our system to identify you as our customer. Other uses of your personal and health information include underwriting your application for insurance and assisting you in a claim for benefits. Your ENL agent, as our business associate, may have access to your health information during the underwriting process, as authorized by you, and access to your personal information for assistance with your insurance needs.

Under our established procedures, if upon the consideration of your medical information we determine you do not meet our underwriting guidelines for the issuance of a policy, the medical reason(s) for a declination of coverage may be disclosed to the person or entity (usually your doctor) who maintains your medical information. Your doctor can then discuss with you, through a private consultation, the medical reason(s) for our decision.

How We Protect This Information
Our employees and agents are required to keep your personal and health information confidential. Our intention is to request or access only the minimum amount of information necessary. We maintain all your personal or health information in a secured database, with security and procedural measures in place, in compliance with federal law, to safeguard your protected information and alert us if and when unauthorized access is attempted.

We do not disclose your personal or health information with any nonaffiliated third party (person, entity or organization) without your written permission, unless allowed or required by law. Under no circumstances will any information be disclosed to any nonaffiliated party for marketing purposes, such as telemarketing, direct mail or electronic mail marketing.

How You Can Access This Information
Write to us and request copies of the personal information we have about you in our records. You can also find out who we have disclosed this information to and for what reason. If you believe any personal or health information we have about you is incomplete, inaccurate or incorrect, you have the right to request that we correct or delete it. If your request concerns health information we received from a doctor, hospital or other medical provider, we will refer you to that person or entity. You may, in a private consultation with them, have the necessary corrections made to your health information and sent to us.

The MIB Inc.
Information regarding your insurability will be treated as confidential. Equitable National Life Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB, toll free, at 1-866-692-6901 (TTY 1-866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Equitable National Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

If you have any questions about this Notice, we can be contacted at:

Equitable National Life Insurance Company
PO Box 2730, Salt Lake City, UT 84110-2730
ATTN: Privacy Officer
Telephone (888) 352 5170

Leave with Applicant