Outline of coverage

Protection Series℠–

Hospital Indemnity Flex Insurance Plan

Policy Forms CLIHIPL117 MA

Hospital Confinement

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

Massachusetts

AetnaSeniorProducts.com

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CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE

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LIMITED BENEFIT FIXED INDEMNITY POLICY

OUTLINE OF COVERAGE FOR POLICY FORM: CLIHIPL117 MA

RETAIN THIS OUTLINE FOR YOUR RECORDS

THIS IS A LIMITED BENEFIT FIXED INDEMNITY 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. The policy sets forth in detail, the rights and obligations of both you and the insurance company. It is therefore important that you READ YOUR POLICY CAREFULLY!

This coverage is designed to provide you with coverage paying benefits only when certain losses occur which result in a hospital or skilled nursing facility stay. This policy provides limited coverage issued to supplement coverage you already have in force.

PREMIUM AGREEMENT: Premiums for the Policy may be changed. Premium changes are subject to the approval of the Commissioner of Insurance. Any change in premium will apply to all Insured Persons with Your same Policy type based on the issue state of the Policy. Any change in premium may occur on the next premium due date after We give You at least 30 days advance notice in writing of such premium change.

The Policy provides a free look period for returning the policy for a refund. You have 30 days after receipt of the Policy to examine its provisions. During that 30-day period, if You are dissatisfied with the Policy, it may be returned to the Company at its Home Office or to the agent from whom it was purchased. Immediately upon such return, the Policy shall be void from the beginning and any premium paid will be promptly refunded.

COMPLAINTS: If you have a complaint, call your agent. If you are not satisfied, you may write or call the Massachusetts Division of Insurance.

Notice to Buyer: THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from the Company.

BENEFIT DESCRIPTIONS

Hospital Confinement Indemnity Benefit - This Benefit will pay a Hospital Confinement Indemnity Benefit Amount only if you are Confined in a Hospital and only one time per Period of Care. Benefits are available in $250 units up to a maximum benefit amount of $4,000.

Optional Daily Hospital Confinement Indemnity Benefit - Rider This Benefit will pay a daily Hospital Confinement Indemnity Benefit Amount when you are Confined in a Hospital. The Daily Hospital Confinement Indemnity Benefit will be paid for each day of such Hospital Confinement. This benefit is available in $10 units, subject to minimum daily Benefit Amounts, up to the maximum daily Benefit Amount of $1,000. The benefit is limited to the maximum number of days per Period of care and the lifetime maximum number of days.

Observation Unit Indemnity Benefit – This Benefit will pay the Observation Unit Indemnity Benefit Amount only if you receive services in an Observation Unit of a Hospital. This Benefit is limited to 50% of the Daily Hospital Confinement Indemnity Benefit and only one time per Period of Care. This benefit is not payable if the daily hospital confinement indemnity benefit is paid.

Optional Daily Skilled Nursing Facility Indemnity Benefit Rider - This Benefit will pay for each day of skilled care received at a Skilled Nursing Facility provided all of the following conditions are met:

1. Your Physician has ordered the services you need for skilled care on a daily basis and the can only be provided in a Skilled Nursing Facility;
2. Admission to the Skilled Nursing Facility immediately follows a Hospital Confinement of at least three (3) consecutive days; and
3. The skilled care is received on a Covered Day.

This benefit is available in $10 units up to a maximum daily benefit amount of $500. There is also a choice of covered days: Days 1-20, Days 21-100 or Days 1-100. This benefit is limited to the daily Benefit Amount and the maximum number of Covered Days per Period of Care you choose. There is no lifetime maximum number of Covered Days for this benefit.

Optional Outpatient Physician Office Visit Indemnity Benefit Rider - This Benefit will pay an Outpatient Physician Office Visit Indemnity Benefit when your Physician requires a follow up visit upon discharge from the Hospital for a Covered Illness or Covered Injury.

Visits for Preventive Care, Mental and Nervous Disorders, Substance Use Disorders and Pregnancy are not covered under this Benefit.

This benefit will not exceed the maximum Benefit Amount and maximum number of visits per Calendar Year. Benefit amounts available in $10 units up to maximum benefit amount of $100 per visit.

Optional Hospital Emergency Room Visit or Ambulance Service Indemnity Benefit Rider - This Benefit will pay a Hospital Emergency Room visit or Ambulance Service Indemnity Benefit when the Insured has an Emergency Room visit or has Ambulance Service by air, ground or water. Services must be Medically Necessary and be provided on an Emergency basis. Only one Benefit Amount per day is payable even if the Insured has an Emergency Room visit and an Ambulance Service on the same day.

This benefit will not exceed the maximum Benefit Amount and maximum number of visits or services per Calendar Year. Benefit amount for this service is $200 increments up to $600.

Optional Rehabilitation Services Indemnity Benefit Rider – This Benefit will pay the Outpatient Rehabilitation Services Indemnity Benefit Amount shown on the Schedule of Benefits page for each day you receive one of the following therapies on an Outpatient basis for treatment of a Covered Illness or Covered Injury after the Insured has been hospitalized:

1. Occupational Therapy;
2. Physical Therapy; or
3. Speech Therapy.

This benefit will not exceed the maximum Benefit Amount and maximum number of visits per Calendar Year. Benefit amounts available in $10 units up to maximum benefit amount of $250 per visit.

RENEWABILITY

The policy is guaranteed renewable for life provided premiums are paid when due. Policy is subject to the Policy Termination provisions.

LIMITATIONS AND EXCLUSIONS

With respect to all benefits provided by this Policy, no benefits will be payable for:

(1) Treatment, Services or supplies including:

   a. Experimental or Investigational procedures or participation in clinical trials,
   b. Diagnostic lab testing, x-rays, Advanced Studies and venipuncture,
   c. Cosmetic surgery, routine foot care, dental services, acne or varicose veins
   d. Allergy testing and allergy injections,
   e. Speech therapy, occupational therapy and physical therapy,
   f. Pre-employment or pre-marital examination or routine physical examinations,
   g. Therapy or treatment of learning disorders or disabilities, developmental delays, Mental or Nervous Disorders or sleep disorders,
   h. Programs, treatment or procedures for tobacco cessation or Substance Use Disorders; and
   i. Obesity, extreme obesity, morbid obesity or weight reduction, including, but not limited to, wiring of the teeth and all forms of surgery including, but not limited to, bariatric surgery, intestinal bypass surgery and complications resulting from any such surgery

(2) Eye examinations, eyeglasses, or contact lenses to correct refractive errors and related services including surgery performed to eliminate the need for eyeglasses, for refractive errors such as radial keratotomy or keratoplasty, treatment for cataracts, orthoptics and visual eye training.

(3) Hospice Care, Custodial Care or Home Health Care

(4) Pregnancy and reproduction:
   a. Pregnancy and related services; except for Complications of Pregnancy,
   b. Infertility and impregnation procedures, such as but not limited to, artificial insemination, in-vitro fertilization, embryo and fetal implantation and G.I.F.T. (gamete intrafallopian transfer),
   c. Voluntary sterilization or reversal thereof,
   d. Voluntary abortion, except with respect to the Insured: (a) where such Insured's life would be endangered if the fetus were carried to term; or (b) where medical complications have arisen from an abortion,
   e. Routine newborn care, including routine nursery charges; and
   f. Treatment of sexual function, dysfunction or inadequacy; or treatment to enhance sexual performance or desire.

(5) War or an act of war, riot or an act of international armed conflict.

(6) The commission or attempted commission of a crime or felony or while engaged in an illegal act; or while imprisoned.

(7) Suicide or attempted suicide or intentionally self-inflicted injury, whether while sane or insane.

(8) Treatment, services and supplies resulting from participation in skydiving, scuba diving, hang or ultra light gliding, ballooning, bungee jumping, parakiting, riding an all-terrain vehicle such as a dirt bike, snowmobile or go-cart, racing with a motorcycle, motor vehicle, boat or any form of aircraft, any participation in sports for pay or profit, or participation in rodeo contests.

(9) Injury sustained while operating a motor vehicle where the Insured's blood alcohol level, as defined by law, exceeds that level permitted by law or otherwise violates legal standards for a person operating a motor vehicle in the state where the injury occurred.
(10) Medical treatment, services and supplies received outside of the United States.

COVERAGE TERMINATION

An Insured Person's Coverage under this Policy will terminate:

1. The date We receive Your written request to cancel Your Policy or on a later date that is requested by You.
2. The Premium Due Date, if sufficient premium has not been paid before the end of the Grace Period; and
3. The date of death of the Policy Owner

PREMIUM INFORMATION

Age Group	Per $250 Hospital Admission Benefit	Per $10 Daily Hospital Benefit 20 days	Per $10 Dr Visit Benefit	Per $10 SNF Benefit-Days 1-20	Per $10 SNF Benefit-Days 21-100	Per $10 SNF Benefit-Days 1-100	Per $200 Emerg/Amb Benefit	Per $50 PT Benefit 15 days	Per $50 PT Benefit 30 days
18-24	$ 37.40	$ 6.80	$18.25	$ 1.30	$ 1.50	$ 2.70	$ 82.50	$22.25	$25.65
25-29	$ 37.40	$ 6.80	$18.25	$ 1.30	$ 1.50	$ 2.70	$ 82.50	$22.25	$25.65
30-34	$ 37.40	$ 6.80	$18.25	$ 1.3	$ 1.50	$ 2.70	$ 82.50	$22.25	$25.65
35-39	$ 37.40	$ 6.80	$18.25	$ 1.30	$ 1.50	$ 2.70	$ 82.50	$22.25	$25.65
40-44	$ 42.60	$ 8.20	$19.90	$ 1.30	$ 1.50	$ 2.70	$ 82.50	$24.10	$27.75
45-49	$ 49.70	$ 9.90	$21.83	$ 1.30	$ 1.50	$ 2.70	$ 82.50	$25.90	$29.80
50-54	$ 59.30	$ 12.00	$23.95	$ 2.50	$ 2.40	$ 4.80	$ 82.50	$27.25	$31.35
55-59	$ 71.10	$ 14.50	$27.03	$ 3.50	$ 4.00	$ 7.50	$ 82.50	$28.20	$32.40
60-64	$ 85.30	$ 17.30	$30.35	$ 5.00	$ 6.60	$ 11.60	$ 86.20	$28.65	$32.95
65-69	$ 109.00	$ 21.60	$33.18	$ 5.50	$ 11.20	$ 16.70	$ 100.80	$28.65	$32.95
70-74	$ 132.70	$ 27.80	$35.10	$ 9.10	$ 18.50	$ 27.50	$ 117.40	$28.65	$32.95
75-79	$ 158.80	$ 34.90	$35.10	$ 14.50	$ 30.00	$ 44.50	$ 132.90	$28.65	$32.95
80-84	$ 180.10	$ 41.20	$35.10	$ 21.80	$ 47.30	$ 69.10	$ 146.60	$28.65	$32.95
85-89	$ 196.70	$ 45.00	$35.10	$ 29.50	$ 65.50	$ 95.00	$ 151.30	$28.65	$32.95

How to calculate premium: Example - Age 55

	No. of Units	Benefit Amt.	Premium Amt.
Hospital Admission benefit:	3	750	213.30
Daily hospital benefit:	10	100	145.00
Skilled nursing benefit			
Covered Days: 21-100	10	100	40.00
Physician visit benefit:	6	60	162.18
Emergency Room/Ambulance benefit:	1	200	82.50
		Total Annual Premium:	$602.68

Payment options
You have a choice among several payment options or modes for paying your premium – annual, semi-annual, quarterly, and monthly bank draft. Each payment mode, other than annual and monthly bank draft, results in higher total yearly premium costs. Reasons for higher costs include added collection and administrative costs, time value of money considerations, and lapse rates.

The annual and monthly bank draft modes have the same total yearly premium costs. As a result, there is a time value of money advantage to you for paying monthly versus annually. However, there may be other advantages to you for choosing an annual payment based on your preferences. Your agent can explain the differences in modes and help you decide which is best for you. You have the right to change your payment mode, among the modes available, during the life of your policy.

Payment Modes
Annual.....Annual x 1
Semi-annual.....Annual x .52
Quarterly.....Annual x .265
Monthly.....Annual x .08333