Outline of coverage

Protection Series℠–

Hospital Indemnity Flex Insurance Plan

Policy Forms CLIHIPL217 VA

Daily Hospital Confinement

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

Virginia

AetnaSeniorProducts.com

CLIHF05997VA

050323

CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE

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FIXED INDEMNITY POLICY

OUTLINE OF COVERAGE FOR POLICY FORM: CLIHIPL217 VA

RETAIN THIS OUTLINE FOR YOUR RECORDS

THIS IS A 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.

BENEFIT DESCRIPTIONS

Daily Hospital Confinement Indemnity Benefit - 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, subject to minimum daily Benefit Amounts, units up to the maximum daily Benefit Amount of $1,000. Additional coverage is also available in $10 units, up to a daily maximum of $1,000. The benefit is limited to the maximum number of days per Period of care and the lifetime maximum number of days. This benefit is $30 per day for 31 days. An additional benefit of $10-$1,000 can be selected in $30 units for 3-30 days. 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 services must be ones that, as a practical matter, 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 the Insured has a Physician Office Visit 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 Outpatient Surgical Procedure Indemnity Benefit Rider - This Benefit will pay an Outpatient Surgical Indemnity Benefit when an Insured has an Outpatient Surgical Procedure performed at an Ambulatory Surgical Center or an Outpatient Surgical Facility for a Covered Illness or Covered Injury.

If the Insured has more than one Surgical Procedure performed at the same time, We will pay only one Outpatient Surgical Procedure Indemnity Benefit Amount even if the Surgical Procedure is caused by more than one Covered Illness or Covered Injury.

This benefit will not exceed the maximum Benefit Amount and maximum number of visits per Calendar Year. Benefits are available in $250 units up to maximum benefit of $3,000 per surgical procedure.

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:

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 $50 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.

PREMIUM AGREEMENT

Premiums for the policy may be changed. Any change in premium will apply to all covered persons with Your same Policy type based on the issue state of Your Policy. Any change in premium may occur on the next premium due date after You are given at least 30 days advance notice in writing of such change.

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, except that cosmetic surgery will not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part,
d. routine foot care, dental services, acne or varicose veins
e. Allergy testing and allergy injections,
f. Speech therapy, occupational therapy and physical therapy, except if specified in the Outpatient Rehabilitation Services Indemnity Benefit Rider attached to this Policy,
g. Pre-employment or pre-marital examination or routine physical examinations,
h. Therapy or treatment of learning disorders or disabilities, developmental delays, Mental or Nervous Disorders or sleep disorders,
i. Programs, treatment or procedures for tobacco cessation or Substance Use Disorders; and
j. 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, Pregnancy resulting from rape or incest, which was reported to police within 7 days following its occurrence will be covered to the same extent as any other covered Accident. The 7-day requirement will be extended to 180 days in the case of an act of rape or incest of a female under 13 years of age,
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 or riot.

(6) Participation in a felony or while engaged in an illegal occupation.

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

(8) Treatment, services and supplies resulting from aviation, except as a fare-paying passenger.

(9) Injury sustained resulting from the Insured's being drunk, or under the influence of any narcotic unless taken on the advice of a Physician.

(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 notice to cancel Your Policy or on a later date that is specified by You.
2. The end of the Grace Period, if sufficient premium has not been paid; and
3. The date of death of the Policy Owner

PREMIUM INFORMATION

	Base	Additional Daily Hospital Benefit								
Age Group	Per $30 Daily Hospital Benefit 31 days	Per $10 3 days	Per $10 4 days	Per $10 5 days	Per $10 6 days	Per $10 7 days	Per $10 8 days	Per $10 9 days	Per $10 10days	Per $10 20 days
18-24	$22.60	$4.40	$4.80	$5.10	$5.30	$5.50	$5.60	$5.70	$6.00	$6.80
25-29	$22.60	$4.40	$4.80	$5.10	$5.30	$5.50	$5.60	$5.70	$6.00	$6.80
30-34	$22.60	$4.40	$4.80	$5.10	$5.30	$5.50	$5.60	$5.70	$6.00	$6.80
35-39	$22.60	$4.40	$4.80	$5.10	$5.30	$5.50	$5.60	$5.70	$6.00	$6.80
40-44	$27.30	$4.40	$4.80	$5.10	$5.30	$5.50	$5.60	$5.70	$6.00	$8.20
45-49	$33.00	$4.60	$5.40	$5.70	$6.10	$7.10	$7.50	$8.00	$9.30	$9.90
50-54	$40.00	$5.40	$6.30	$6.60	$7.10	$8.30	$8.80	$9.40	$10.90	$12.00
55-59	$48.00	$6.20	$7.20	$7.70	$8.20	$9.50	$10.10	$10.70	$12.40	$14.50
60-64	$57.60	$7.00	$8.20	$8.70	$9.30	$10.70	$11.40	$12.10	$14.00	$17.30
65-69	$71.90	$8.00	$9.30	$9.90	$10.50	$12.20	$13.00	$13.80	$16.00	$21.60
70-74	$92.60	$9.70	$11.30	$12.10	$12.80	$14.50	$15.20	$16.00	$18.00	$27.80
75-79	$116.60	$11.50	$13.50	$14.40	$15.30	$17.20	$18.20	$19.10	$21.50	$34.90
80-84	$137.20	$13.50	$15.70	$16.80	$17.90	$20.20	$21.40	$22.50	$25.30	$41.20
85-89	$149.90	$14.30	$16.50	$17.60	$18.70	$21.70	$23.20	$24.60	$28.50	$45.00

Riders							
Per $10 SNF Benefit-Days 1-20	**Per $10 SNF Benefit-Days 21-100**	**Per $10 SNF Benefit-Days 1-100**	**Per $10 Dr Visit Benefit 20 days**	**Per $250 Outpatient Surgery Benefit**	**Per $200 Emerg/Amb Benefit**	**Per $50 PT Benefit 15 Days**	**Per $50 PT Benefit 30 Days**
$1.30	$1.50	$2.70	$73.00	$59.10	$82.50	$44.50	$51.30
$1.30	$1.50	$2.70	$73.00	$59.10	$82.50	$44.50	$51.30
$1.30	$1.50	$2.70	$73.00	$59.10	$82.50	$44.50	$51.30
$1.30	$1.50	$2.70	$73.00	$59.10	$82.50	$44.50	$51.30
$1.30	$1.50	$2.70	$79.60	$68.20	$82.50	$48.20	$55.50
$1.30	$1.50	$2.70	$87.30	$79.50	$82.50	$51.80	$59.60
$2.50	$2.40	$4.80	$95.80	$90.90	$82.50	$54.50	$62.70
$3.50	$4.00	$7.50	$108.10	$104.50	$82.50	$56.40	$64.80
$5.00	$6.60	$11.60	$121.40	$120.50	$86.20	$57.30	$65.90
$5.50	$11.20	$16.70	$132.70	$129.50	$100.80	$57.30	$65.90
$9.10	$18.50	$27.50	$140.40	$129.50	$117.40	$57.30	$65.90
$14.50	$30.00	$44.50	$140.40	$129.50	$132.90	$57.30	$65.90
$21.80	$47.30	$69.10	$140.40	$129.50	$146.60	$57.30	$65.90
$29.50	$65.50	$95.00	$140.40	$129.50	$151.30	$57.30	$65.90

How to calculate premium- Age 55

	No. of Units	Benefit Amt.	Premium Amt.
Daily hospital Benefit-Base 31 Days	1	30	$48.00
Daily hospital Benefit-20 days (additional)	10	100	$ 145.00
Skilled nursing benefit			$ -
Covered Days 21-100	10	100	$ 40.00
Physician visit benefit	6	60	$ 648.60
Outpatient surgery benefit	3	750	$ 313.50
Emergency room/ambulance benefit	1	200	$ 82.50
Total Annual Premium			$1,277.60

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