Outline of coverage

Protection Series℠–

Hospital Indemnity Flex Insurance Plan

Policy Forms CLIHIPL117ID A

Hospital Confinement

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

Idaho

aetnaseniorproducts.com

CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE

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LIMITED BENEFIT FIXED INDEMNITY POLICY

OUTLINE OF COVERAGE FOR POLICY FORM: CLIHIPL117ID A

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.

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.

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 $40 per day for 31 days. An additional benefit of $10-$1,000 can be selected in $10 units for 3-10 or 20 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 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.

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. Cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part, and reconstructive surgery because of Congenital Anomaly or disease of a covered dependent child.
b. foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet,
c. Pre-employment or pre-marital examination or routine physical examinations,
d. Mental or emotional disorders, alcoholism and drug addiction,

(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) Rest cures, custodial care, transportation.

(4) Pregnancy, except for Complications of Pregnancy;

(5) Routine newborn care, including routine nursery charges;

(6) War or an act of war (whether declared or undeclared), riot or insurrections, service in the armed forces or units auxillary to it.

(7) Participation in a felony.

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

(9) Treatment, services and supplies resulting from participation in professional 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 professional participation in rodeo contests.

(10) 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.

(11) Medical treatment, services and supplies received outside of the United States.

(12) Expenses for elective abortion for any reason other than to preserve the life of the female covered person upon whom the abortion is performed

(13) Pre-existing conditions or diseases, except for Congenital Anomalies of a covered Dependent Child.

(14) Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of it, where the interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column.

(15) Benefits provided under Medicare or other governmental program (except Medicaid), a state or federal workers' compensation law, employers liability or occupational disease law, or motor vehicle no-fault law; services performed by a member of the covered person's immediate family; and services for which no charge is normally made in the absence of insurance.

(16) Dental care or treatment.

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	Per $10 Daily Hospital Benefit 20 Days	SNF Benefit-Days 1-20	SNF Benefit-Days 21-100	SNF Benefit-Days 1-100
18-24	$41.10	$7.50	$1.40	$1.60	$3.00
25-29	$41.10	$7.50	$1.40	$1.60	$3.00
30-34	$41.10	$7.50	$1.40	$1.60	$3.00
35-39	$41.10	$7.50	$1.40	$1.60	$3.00
40-44	$46.90	$9.00	$1.40	$1.60	$3.00
45-49	$54.70	$10.90	$1.40	$1.60	$3.00
50-54	$65.20	$13.20	$2.70	$2.60	$5.30
55-59	$78.20	$15.90	$3.80	$4.40	$8.20
60-64	$93.80	$19.00	$5.50	$7.30	$12.80
65-69	$119.90	$23.80	$6.10	$12.30	$18.40
70-74	$146.00	$30.60	$10.00	$20.30	$30.30
75-79	$174.70	$38.40	$16.00	$33.00	$49.00
80-84	$198.10	$45.30	$24.00	$52.00	$76.00
85-89	$216.40	$49.50	$32.50	$72.00	$104.50

How to calculate premium: Example - Age 55

	No. of Units	Benefit Amt.	Premium Amt.
Hospital Admission benefit:	3	750	234.60
Daily hospital benefit:	10	100	159.00
Skilled nursing benefit			
Covered Days: 21-100	10	100	44.00
		Total Annual Premium:	$437.60

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