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Outline of Coverage

Hospital Indemnity Insurance

Policy Forms CLIHIPL14

Underwritten by
An Aetna Company **Continental Life Insurance Company**
of Brentwood, Tennessee

**CONTINENTAL LIFE INSURANCE COMPANY OF
BRENTWOOD, TENNESSEE**

800 Crescent Centre Dr., Suite 200
Franklin, Tennessee 37067
1-800-264-4000

LIMITED BENEFIT FIXED INDEMNITY POLICY

OUTLINE OF COVERAGE FOR POLICY FORMS: CLIHIPL14

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. Only the actual policy provisions will control. 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 only supplemental 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 \$2500.

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 units up to the maximum daily Benefit Amount of \$300. The benefit is limited to the maximum number of days per Period of care and the lifetime maximum number of days

Daily Skilled Nursing Facility Indemnity Benefit- 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 \$200. 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. The number of lifetime Covered Days is unlimited.

Outpatient Physician Office Visit Indemnity Benefit- 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 \$60 per visit.

Outpatient Surgical Procedure Indemnity Benefit- We 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 \$1500 per surgical procedure.

Hospital Emergency Room Visit or Ambulance Service Indemnity Benefit- 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. Maximum benefit amount for this service is \$200.

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, 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. Sex transformation; treatment of sexual function, dysfunction or inadequacy; or treatment to enhance sexual performance or desire.
- (5) War or an act of war, riot or in the commission or attempted commission of an assault or felony. This includes 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, hand 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	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 \$250 Outpatient Surgery Benefit	Per \$200 Emerg/Amb Benefit
18-24	\$ 41.10	\$ 7.30	\$ 80.30	\$ 1.30	\$ 1.60	\$ 2.90	\$ 65.00	\$ 90.70
25-29	\$ 41.10	\$ 7.30	\$ 80.30	\$ 1.30	\$ 1.60	\$ 2.90	\$ 65.00	\$ 90.70
30-34	\$ 41.10	\$ 7.30	\$ 80.30	\$ 1.30	\$ 1.60	\$ 2.90	\$ 65.00	\$ 90.70
35-39	\$ 41.10	\$ 7.30	\$ 80.30	\$ 1.30	\$ 1.60	\$ 2.90	\$ 65.00	\$ 90.70
40-44	\$ 46.90	\$ 8.90	\$ 87.60	\$ 1.30	\$ 1.60	\$ 2.90	\$ 75.00	\$ 90.70
45-49	\$ 54.70	\$ 10.70	\$ 95.90	\$ 1.30	\$ 1.90	\$ 3.20	\$ 87.50	\$ 90.70
50-54	\$ 65.20	\$ 13.00	\$ 105.30	\$ 2.70	\$ 2.60	\$ 5.30	\$ 100.00	\$ 90.70
55-59	\$ 78.20	\$ 15.60	\$ 118.90	\$ 3.80	\$ 4.40	\$ 8.20	\$ 115.00	\$ 90.70
60-64	\$ 93.80	\$ 18.80	\$ 133.50	\$ 5.50	\$ 7.30	\$ 12.80	\$ 132.50	\$ 94.80
65-69	\$ 119.90	\$ 23.50	\$ 146.00	\$ 7.40	\$ 10.20	\$ 17.60	\$ 142.50	\$ 110.90
70-74	\$ 146.00	\$ 30.20	\$ 154.30	\$ 10.50	\$ 19.30	\$ 29.80	\$ 142.50	\$ 129.00
75-79	\$ 174.70	\$ 38.10	\$ 154.30	\$ 14.70	\$ 32.30	\$ 47.00	\$ 142.50	\$ 146.20
80-84	\$ 198.10	\$ 44.80	\$ 154.30	\$ 23.10	\$ 51.10	\$ 74.20	\$ 142.50	\$ 161.30
85-89	\$ 216.40	\$ 49.00	\$ 154.30	\$ 28.40	\$ 73.00	\$ 101.40	\$ 142.50	\$ 166.30

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	156.00
Skilled nursing benefit			
Covered Days: 21-100	10	100	44.00
Physician visit benefit:	6	60	713.40
Outpatient surgery benefit:	3	750	345.00
Emergency Room/Ambulance benefit:	1	200	90.70
Total Annual Premium:			\$1583.70

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

