GUARANTEE TRUST LIFE INSURANCE COMPANY
A Mutual Company
1275 Milwaukee Avenue, Glenview, Illinois 60025
(800) 338-7452

LIMITED BENEFIT POLICY
Providing Dental and Vision Benefits
Guaranteed Renewable for Life
Premiums May Be Changed By Class

OUTLINE OF COVERAGE
for Policy Form G15DV-CT

THIS POLICY PROVIDES LIMITED BENEFITS DURING THE FIRST 12 MONTHS AFTER THE POLICY EFFECTIVE DATE. PLEASE READ YOUR POLICY CAREFULLY.

KEEP THIS OUTLINE FOR YOUR RECORDS

THIS IS NOT A MEDICARE SUPPLEMENT POLICY

THIS IS A LIMITED BENEFIT 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 and only the actual policy provisions will control. Your policy sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

LIMITED BENEFIT COVERAGE. This policy is designed to provide, to persons insured, Limited Benefit Coverage in the form of a Dental and Vision Benefit, subject to any limitations set forth in the policy.

BENEFITS.

We will only pay benefits for limited dental and vision procedures that are Medically Necessary and begin while the Policy is in force.

DENTAL AND VISION BENEFIT. After You satisfy the Policy Deductible Amount, We will pay the Insured Percent of covered expenses up to the Policy Maximum Amount per Calendar Year, subject to the timeframes below. The Policy Deductible, Insured Percent and the Policy Maximum Amounts are shown in the Policy Schedule. This Policy is not subject to reduction at age 65. Benefits during the first Calendar Year are 50% of the selected benefit amount. After 12 months, the full selected benefit level is provided.

Dental and Vision Policy Amount Selected: ☐ $400 ☐ $800 ☐ $1200

1. **Dental:**
We will pay up to the Policy Maximum Amount for services of a licensed Dentist including one annual examination and cleaning, x-rays, the cost of fillings, prophylaxis, bridges, crowns, dentures and outpatient dental surgery prescribed as necessary by a Dentist, according to the timeframes below and subject to any applicable Policy Deductible Amount.

   After this Policy has been in force three (3) months, we will pay the cost of one (1) annual dental exam, x-rays and cleaning, occurring after such three (3) month period.

   After this Policy has been in force six (6) months, we will pay benefits for fillings or root canal treatment occurring after such six (6) month period.

   After this Policy has been in force twelve (12) months, we will pay benefits for bridges, crowns, full dentures or partials, any services or treatment relating to the replacement of natural teeth which were missing on this Policy's Effective Date, out-patient dental surgery, "full mouth" extractions or fluoride treatments occurring after such twelve (12) month period. After this Policy has been in force twelve (12) months, we will pay benefits for replacement or repair of existing bridges or dentures occurring after such twelve (12) month period.

2. **Vision:**
We will pay up to the Policy Maximum Amount for visits to a licensed ophthalmologist or optometrist for the purpose of eye refractions and examinations, including the cost of eyeglasses or contact lenses as prescribed by such doctor, according to the timeframes below and subject to the Policy Maximum Amount per Calendar Year.

   After this Policy has been in force three (3) months, we will pay the cost of one (1) eye exam or one (1) eye refraction, occurring after such three (3) month period, up to the Eye Exam Maximum each Calendar Year as shown in the Policy Schedule.

   After this Policy has been in force six (6) months, we will pay benefits for eyeglasses or contact lenses purchased after such six (6) month period, not to exceed the Prescription Eyewear maximum of $200 per Calendar year.

DENTAL AND VISION POLICY EXCLUSIONS.
Benefits will not be paid for dental expenses arising from or in connection with:

- A service not furnished by a Dentist, except:
  - That performed by a Dental Hygienist under the supervision of a Dentist; and
  - X-rays ordered by a Dentist.
- Treatment, services or supplies which:
  - Are not Necessary Dental Treatment, except as provided herein;
  - Are Experimental/Investigational in nature;
- Conditions arising out of or in the course of employment and which is payable or covered under any Workers' Compensation or Occupational Disease Act or Law..
- Treatment by a Family Member;
- Services or supplies for which there would be no charge in the absence of insurance;
- A service furnished to You for:
  - Cosmetic purposes, unless needed as a result of Injury. Facing on crowns, on pontics, posterior to the second bicuspid shall always be considered cosmetic; or
  - Dental care of congenital or developmental malformation.
- Implants; replacement of lost or stolen appliances, replacement of orthodontic retainers, athletic mouthguards, precision or semi-precision attachments; denture duplication; or sealants.
- Oral hygiene instructions; plaque control; acid etch; or prescription for take-home fluoride.
- Overdentures and associated procedures.
- Services not completed by the end of the month in which insurance terminates.
- Orthodontic related expense, unless specifically provided.

Benefits will not be paid for vision expenses arising from or in connection with:

- Treatment, services or supplies which:
  - Are Experimental/Investigational in nature;
  - Are received without charge or legal obligation to pay; or
  - Treatment by any Family Member.
- Conditions arising out of or in the course of employment and which is payable or covered under any Workers' Compensation or Occupational Disease Act or Law.;
- Services and supplies in connection with special procedures such as: orthoptics or vision training and subnormal vision aids;
- Non-prescription (plano) eyewear;
- Medical or surgical treatments of the eyes; or
- Eye examinations required by an employer as a condition of employment.

POLICY TERMINATION.
This Policy will terminate on the earliest of:

1. The date the Policy to which this Policy is attached is terminated;
2. The date You ask Us, in writing, to cancel this Policy; or
3. The date the Policy lapses for non-payment of premium.

POLICY PREMIUM.
This Policy requires the payment of premium. We can change the premium for this Policy if We change it for all Policies like Yours in Your state on a class basis.

GUARANTEED RENEWABLE FOR LIFE. You may keep the Policy in force during Your lifetime by paying the renewal premium at the intervals available to You at time of renewal. You must pay the renewal premium by its due date or during the Policy's 31 day grace period. We cannot cancel or refuse to renew the Policy or place any restrictions on it if You pay Your premiums on time.

PREMIUMS SUBJECT TO CHANGE. We may change the premium rates for this Policy by giving You at least 31 days advance written notice of any change in the renewal premium. We can only change the premium if We change it for all Policies like Yours in Your state on a class basis.

INITIAL PREMIUM:
Limited Benefit Dental and Vision Policy: $_____

TOTAL PREMIUM: $_____