

GUARANTEE TRUST LIFE INSURANCE COMPANY

A Mutual Company
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HOSPITAL CONFINEMENT INDEMNITY COVERAGE

Guaranteed Renewable for Life
Premiums May Be Changed By Class

REQUIRED OUTLINE OF COVERAGE

For Policy Form G0553-PA
With Optional Rider Forms RG05SNF-PA, RG05LSH, RG05ASB, RG05DME, and RG05ADD-PA

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!**

HOSPITAL CONFINEMENT INDEMNITY COVERAGE – Policies of this category are designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Such policies do *not* provide any benefits other than the fixed daily indemnity for hospital confinement and any additional benefits described below.

BENEFITS

We will only pay benefits for Hospital Confinements, Emergency Room Services, and Mental Health Hospital Confinements that are Medically Necessary and begin while the Policy is in force.

BENEFIT A : HOSPITAL CONFINEMENT BENEFIT (INJURY OR SICKNESS)

We will pay the Hospital Confinement Indemnity Benefit Amount shown in the application, for each day You are Hospital Confined due to Injury or Sickness. Benefits are subject to the Benefit Period, as shown in the application, for any One Period of Confinement as defined in the Policy.

Hospital Confinement Benefit selected: \$_____ per day [\$50 - \$600 : in \$10 increments]

Benefit Period: 31 days

BENEFIT B: MENTAL HEALTH BENEFIT

We will pay the Mental Health Benefit Amount of \$175, for each day You are Hospital Confined due to a Mental or Nervous Disorder. This benefit is subject to the maximum number of 7 days.

BENEFIT C: EMERGENCY ROOM BENEFIT (INJURY ONLY)

We will pay the Emergency Room Benefit of \$150, for services in a Hospital emergency room or Hospital affiliated emergency care facility for loss due to Injury, provided the Emergency treatment is followed within 24 hours by a covered Hospital Confinement of at least one day. This benefit is payable only once per any One Period of Confinement.

We won't pay benefits under both Benefit A and Benefit B above for the same day of Hospital Confinement.

LIMITATIONS AND EXCLUSIONS:

PRE-EXISTING CONDITION LIMITATION

Pre-existing Condition: A Sickness or Injury for which medical advice or treatment was recommended by, or received from, a Doctor within a 6 month period before the Effective Date.

Pre-existing conditions are not covered unless the loss occurs more than 6 months after Your Effective Date of coverage.

EXCLUSIONS

We won't pay benefits for:

1. Treatment, services or supplies which:
 - Are not Medically Necessary;
 - Are not prescribed by a Doctor as necessary to treat an Sickness or Injury;
 - Are determined to be Experimental/Investigational in nature by Us;
 - Are received without charge or legal obligation to pay;
 - Would not routinely be paid in the absence of insurance;
 - Are received from any Family Member.
 - Are received outside the United States.
2. Expenses incurred as a result of loss due to war, or any action of war, declared or undeclared.
3. Expenses incurred as a result of committing or attempting to commit a felony or participating in a riot or insurrection.
4. Expenses incurred as a result of suicide or intentionally self-inflicted Injury.
5. Sickness or injury covered by any Workmen's Compensation Act of Occupational Disease Law or by United States Longshoreman's Harbor Worker's Compensation Act (33 U.S.C. ss 901- 950).
6. Cosmetic surgery other than:
 - Reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or
 - Reconstructive surgery because of a congenital disease or anomaly.
7. Any loss sustained or contracted in consequence of the Insured's being intoxicated, or under the influence of any narcotic unless administered on the advice of a physician.

OPTIONAL COVERAGE(S): (Available for an additional premium)

Skilled Nursing Facility Benefit Rider RG05SNF-PA

We will pay the Skilled Nursing Benefit Amount of \$120, for each day You are confined in a Skilled Nursing Facility provided that;

1. You have first been Hospital Confined for 3 or more consecutive days;
2. The Skilled Nursing Facility confinement begins within 30 days after such Hospital Confinement;
3. Your Doctor must certify the need for the Skilled Nursing Facility confinement; and
4. The Skilled Nursing Facility confinement is for the same Injury or Sickness as the Hospital Confinement for which We paid benefits.

The Skilled Nursing Facility Benefit Amount is subject to the 20 day Elimination Period and payable for 80 days under Skilled Nursing Maximum Benefit Period. We will not pay more than the 80 days indicated in the Skilled Nursing Maximum Benefit Period for any One Period of Confinement as defined in the Policy.

Lump Sum Hospital Benefit Rider RG05LSH

We will pay the Lump Sum Hospital Benefit Amount when You are Hospital Confined. Lump Sum Hospital Benefits are payable only;

1. When the Hospital Confinement is covered under the Policy to which this Rider is attached; and
2. Once during any One Period of Confinement.

Lump Sum Hospital Benefit Amount Selected: \$250 \$500 \$750

Ambulance Service Benefit Rider RG05ASB

We will pay the Ambulance Service Benefit Amount of \$200, whenever a licensed surface ambulance service transports you to or from a Hospital to which you are Hospital Confined. This Benefit is payable no more than once per Hospital Confinement for all trips. The Hospital Confinement requiring the ambulance service must be Medically Necessary and covered by the Policy. We will not pay more than the Lifetime Maximum Amount of \$2,500.

Durable Medical Equipment Benefit Rider RG05DME

We will pay the Durable Medical Equipment expenses incurred by You due to an Injury or Sickness, subject to the Durable Medical Equipment Percentage of 30% and the Maximum Benefit Amount of \$300 per Calendar Year.

Accidental Death and Dismemberment Benefit Rider RG05ADD-PA

ACCIDENTAL DEATH BENEFIT

We will pay the Loss of Life Benefit selected, to the Beneficiary named in the application (or as later changed) if you die solely as a result of Injuries. Our payment will be subject to all of the provisions of the Policy and this Rider.

DISMEMBERMENT BENEFIT

We will pay the appropriate Dismemberment Benefit, listed on the Schedule, to you if you suffer total and irrecoverable loss of eyesight or limbs solely as the result of an Injury.

Loss means with regard to hands and feet, total and permanent loss of function; with regard to eyes, loss of sight to the extent of legal blindness.

If more than one Loss is sustained as a result of one Accident, We will pay only one amount, the largest to which You are entitled.

