OUTLINE OF COVERAGE - Retain This Form For Your Records.
LIMITED BENEFIT HOSPITAL AND SURGICAL EXPENSE COVERAGE

POLICY FORM MMGAP

Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of Your policy. This outline of coverage is not the insurance contract and only the actual policy provisions will control Your benefits. The policy itself 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 Hospital and Surgical Expense Policy Form MMGAP is designed to provide person’s age 0-63 coverage who currently have a Primary Medical Policy. This policy is subject to any limitations, exclusions, deductibles and copayment requirements set forth in the Primary Medical Policy. Coverage is not provided for unlimited hospital or medical surgical expenses.

BENEFITS - Eligible Hospital and Surgical Expenses
1. Hospital Inpatient Benefit - We will pay benefits equal to 100% of any deductible, coinsurance, and copays for which you are responsible under Your Primary Medical Policy, up to the Maximum Annual Benefit each calendar year, for You or a Family Member’s Inpatient Hospital Stays covered under the Primary Medical Policy.

2. Refund of Premiums for Loss of Life from Injury
   We will refund to you the premiums paid under this policy for the coverage of a Family Member if the death of the Member is due to an Injury.

LIMITATIONS AND EXCLUSIONS
We will not pay benefits under this policy for:
1. Services not covered under the Primary Medical Policy; or
2. Expenses in excess of benefit limits or maximums in the Primary Medical Policy; or
3. Normal pregnancy (including childbirth, false labor, occasional spotting, physician-prescribed rest, morning sickness and similar conditions associated with a difficult pregnancy which do not constitute a distinct complication of pregnancy) or voluntary termination of pregnancy; or
4. Usual and customary routine nursery care, or well-baby care or immunizations; or any other usual and customary routine care and treatment following full term or premature birth, not incident and necessary to the treatment of Injury or Sickness; or
5. Convalescent, skilled nursing, educational care or for nervous or mental disorders, unless covered by Your Primary Health Plan; or
6. Dental treatment, hearing aids or eye refractive exams, refractive surgery or refractive treatment; or
7. Any Inpatient Hospital Stay or other service for which You or a Family Member do not incur a charge; or
8. Any loss covered by any Workmen’s Compensation or Employers’ Liability Law; or
9. Any Inpatient Hospital Stay or other service that is not medically necessary, or is cosmetic in nature; or
10. Any expense incurred in excess of the usual, customary and regular charges for any service or materials in the geographic area where furnished; or
11. Charges incurred for professional radiological, pathological or EKG interpretations, unless covered by Your Primary Medical Policy; or
12. Rehabilitative care services received at a facility not meeting the definition of a Hospital, unless covered by Your Primary Medical Policy; or
13. Treatment or services incurred outside of the U.S. boundaries; or
14. Infertility or sterilization treatment procedures, unless covered by Your Primary Medical Policy.
RENEWAL AGREEMENT
You can continue this policy in force for successive renewal terms of 1 month, 3 months, 6 months, or 12 months
by paying appropriate renewal premiums before the end of the grace period. The appropriate renewal
premiums will be those under Our applicable table of premium rates that is in effect on the respective due
dates of the premiums. We have the right to change the renewal premiums for this policy when We change, and in
accordance with, Our table of premium rates applicable to all policies of this form and class. Class is based on benefit
amounts, sex, and age at issue for Policyholders of this form in Your state.

A grace period of 31 days will be granted for the payment of each renewal premium. The policy will stay in force during the
grace period.

PREMIUM
Your premium for the policy is monthly $______, quarterly $______, semi-annually $______, or annually $_______.
You pay a one time policy fee of $__________.