SCHEDULE OF BENEFITS

To receive the highest level of benefits at the lowest Out-of-Pocket Maximum expense, Covered Services must be provided by PPO Network Providers. When you use Non-Contracting Providers, you are responsible for any balance due between the Provider's charge and the Allowed Amount, in addition to any Deductibles, Copayments, Coinsurance, and Non-Covered Charges. All benefits are calculated based upon the applicable Allowed Amount or Non-Contracting Amount, not the Provider's charge. Refer to "How Claims are Paid" for additional information.

Remember, in an emergency, always go to the nearest appropriate medical facility; your benefits will not be reduced if you go to a Non-PPO Network or Non-Contracting Hospital in an emergency. However, you may be subject to balance billing if you utilize Non-Contracting Providers. Please see the "How Claims are Paid" section of this Benefit Book.

BENEFIT PERIOD AND DEPENDENT AGE LIMIT	
Benefit Period	Calendar year
Dependent Age Limit	The end of the month of the 26th birthday

COMPREHENSIVE MAJOR MEDICAL BENEFIT	
Deductible per Benefit Period for PPO Network Providers	
If you have single coverage:	$200
If you have family coverage:	$400
Deductible per Benefit Period for Contracting, Non-PPO Network Providers and Non-Contracting Providers	
If you have single coverage:	$400
If you have family coverage:	$800
Coinsurance Limit per Benefit Period for PPO Network Providers	
If you have single coverage:	$550
If you have family coverage:	$1,100
Coinsurance Limit per Benefit Period for Contracting, Non-PPO Network Providers and Non-Contracting Providers	
If you have single coverage:	$1,100
If you have family coverage:	$2,200
Out-of-Pocket Maximum per Benefit Period for PPO Network Providers (Includes Deductibles, Copayments, and Coinsurance) (Prescription Drug is not administered by Medical Mutual) (1)	
If you have single coverage:	$750
If you have family coverage:	$1,500
Out-of-Pocket Maximum per Benefit Period for Contracting, Non-PPO Network Providers and Non-Contracting Providers (Includes Deductibles, Copayments, and Coinsurance)	
If you have single coverage:	$1,500
If you have family coverage:	$3,000

Penalty for failure to obtain Preauthorization for services received from a Non-Contracting Provider	$200 (Not applied to the Deductible or Out-of-Pocket Maximum)
Deductible and Out-of-Pocket Maximum Processing (2)	Embedded

After the applicable Out-of-Pocket Maximum shown above has been met, you are no longer responsible for paying any further Copayments, Deductibles or Coinsurance for Covered Charges Incurred during the balance of the Benefit Period.

Any Excess Charges you pay for claims will not accumulate toward any applicable Coinsurance Limit or toward the Out-of-Pocket Maximum.

Any amounts applied to your PPO Network Deductible or PPO Network Coinsurance Limit and Out-of-Pocket Maximum will also be applied to your Non-PPO Network Deductible or Non-PPO Network Coinsurance Limit and Out-of-Pocket Maximum. Any amounts applied to your Non-PPO Network Deductible or Non-PPO Network Coinsurance Limit and Out-of-Pocket Maximum will also be applied to your PPO Network Deductible or PPO Network Coinsurance Limit and Out-of-Pocket Maximum.

It is important that you understand how Medical Mutual calculates your responsibilities under this Benefit Book. Please consult the "HOW CLAIMS ARE PAID" section for necessary information.

To receive maximum benefits, you must use PPO Network Providers. PPO Network Providers may change. Medical Mutual will tell you 60 days before a PPO Network Hospital becomes Non-PPO Network.

Remember, in an emergency, always go to the nearest appropriate medical facility; your benefits will not be reduced if you go to a Non-PPO Network Hospital in an emergency.

BENEFIT MAXIMUMS PER COVERED PERSON	
(per Benefit Period unless otherwise shown)	
Autism Spectrum Disorders • Speech and Language Therapy • Physical Therapy • Occupational	 10 visits, then subject to medical review 25 visits, then subject to medical review 25 visits, then subject to medical review
Professional Outpatient Occupational and Physical Therapy Services and Chiropractic Visits	25 visits (combined), then subject to medical review
Professional Outpatient Speech Therapy Services	10 visits, then subject to medical review
Preventive Chest X-ray, Complete Blood Count (CBC), Comprehensive Metabolic Panel, Electrocardiogram (EKG) and Urinalysis (UA)	One each
Preventive Mammogram Services	One mammogram; mammograms are limited to 130% of the Medicare reimbursement amount; the maximum reimbursement amount applies only to Covered Services received inside the state of Ohio, as mandated by the state of Ohio.
Preventive Pap Tests and Associated Examinations	One test One examination (Age 21 and over)
Preventive Physical Examinations (Age 21 and over)	One examination for males Two examinations for females

COINSURANCE AND COPAYMENTS FOR COVERED SERVICES		
TYPE OF SERVICE (Institutional and Professional)	**For Covered Services received from a PPO Network Provider, you pay the following portion, based on the Allowed Amount**	**For Covered Services received from a Non-PPO Network or a Non-Contracting Provider, you pay the following portion, based on the applicable Allowed Amount or Non-Contracting Amount (3)**
IF A DEDUCTIBLE APPLIES, ALL COVERED SERVICES ARE SUBJECT TO THE DEDUCTIBLE, UNLESS "NOT SUBJECT TO THE DEDUCTIBLE" IS SPECIFICALLY STATED.		
EMERGENCY ROOM SERVICES		
The Institutional Charge for use of the Emergency Room for an Emergency Medical Condition	$250 Copayment, waived if admitted, not subject to the Deductible	
Emergency Room Physician's Charges for an Emergency Medical Condition	0%, not subject to the Deductible	
All other related Charges for an Emergency Medical Condition	0%, not subject to the Deductible	
The Institutional Charge for use of the Emergency Room in a **non-emergency**	10%	20%
Emergency Room Physician's Charges in a **non-emergency**	10%	20%
All other related Charges in a **non-emergency**	10%	20%
INPATIENT SERVICES		
Maternity	10%	20%
Physical Medicine and Rehabilitation	10%	20%
Semi-Private Room and Board	10%	20%
Skilled Nursing Facility	10%	20%
MENTAL HEALTH CARE, DRUG ABUSE AND ALCOHOLISM SERVICES		
Mental Health Care, Drug Abuse and Alcoholism Services	Any applicable Deductible, Out-of-Pocket Maximum or Copayment corresponds to the type of service received and is payable on the same basis as any other illness (e.g., emergency room visits for a Mental Illness will be paid according to the Emergency Services section above).	
OUTPATIENT REHABILITATIVE SERVICES		
Cardiac Rehabilitation Services	10%	20%
Chiropractic Services	10%	20%
Occupational Therapy Services	10%	20%
Physical Therapy Services	10%	20%
Pulmonary Therapy Services	10%	20%
Respiratory Therapy Services	10%	20%
Speech Therapy Services	10%	20%
PHYSICIAN/OFFICE SERVICES (includes Mental Health and Substance Abuse Disorders)		
Certain immunizations not covered under PPACA (4)	10%	20%
Medically Necessary Office Visits	10%	20%

COINSURANCE AND COPAYMENTS FOR COVERED SERVICES		
TYPE OF SERVICE (Institutional and Professional)	**For Covered Services received from a PPO Network Provider, you pay the following portion, based on the Allowed Amount**	**For Covered Services received from a Non-PPO Network or a Non-Contracting Provider, you pay the following portion, based on the applicable Allowed Amount or Non-Contracting Amount (3)**
IF A DEDUCTIBLE APPLIES, ALL COVERED SERVICES ARE SUBJECT TO THE DEDUCTIBLE, UNLESS "NOT SUBJECT TO THE DEDUCTIBLE" IS SPECIFICALLY STATED.		
Urgent Care Office Visits	$25 Copayment, not subject to Deductible	20%
PREVENTIVE AND WELLNESS SERVICES		
Preventive Services are provided in accordance with state and federal law. Please refer to the "Preventive and Wellness Services" health care benefit for details. (5)	0%, not subject to the Deductible	20%
Colonoscopy and Sigmoidoscopy (45-75)	0%, not subject to the Deductible	20%
Colonoscopy and Sigmoidoscopy (age 76 and over) (6)	0%, not subject to the Deductible	20%
Testing Services • bone density tests • chest x-ray • complete blood count (CBC) • comprehensive metabolic panel • electrocardiogram (EKG) • prostate specific antigen (PSA) tests • urinalysis (UA)	0%, not subject to the Deductible	20%
SURGICAL SERVICES		
Inpatient Surgery	10%	20%
Medically Necessary Endoscopic Procedures (i.e, Colonoscopy, Sigmoidoscopy, etc.)	10%	20%
Outpatient Surgery	10%	20%
OTHER SERVICES		
Ambulance Services	20%	
Diabetic Supplies	0%, not subject to the Deductible	20%
All Other Covered Services	10%	20%

Comprehensive Major Medical Notes

1. Prescription Drug benefits that accumulate toward the Out-of-Pocket Maximum are provided under a separate arrangement between the Group and the Group's pharmacy benefits manager and are not part of this Plan administered by Medical Mutual.
2. "Embedded processing" - A family plan with two kinds of Deductibles and Out-of-Pocket Maximums: one for an individual family member and one for the whole family. With family coverage, each Covered Person's Out-of-Pocket Maximum will not exceed the PPO Network Out-of-Pocket Maximum for single coverage shown on the Schedule of Benefits.
3. The Coinsurance percentage will be the same for Non-Contracting Providers as Non-PPO Network Providers, but for Non-Contracting Providers, you may still be subject to balance billing and/or Excess Charges. Payments to

Contracting Non-PPO Network Providers are based on the Allowed Amount. Payments to Non-Contracting Providers are based on the Non-Contracting Amount.

4. Contact Customer Care for more details.
5. Preventive services include evidence-based services that have a rating of "A" or "B" in the United States Preventive Services Task Force, preventive immunizations and other screenings, as provided for in the Patient Protection and Affordable Care Act.
6. If a diagnosis of a medical Condition is made during the screening (e.g., removal of a polyp), the procedure is no longer considered preventive and may be considered a diagnostic procedure under Surgical Services.