PPO NETWORK COMPREHENSIVE MAJOR MEDICAL SCHEDULE OF BENEFITS

Benefit Period	July 1st to June 30th
Dependent Age Limit	The end of the month of the 26th birthday.
PPO Network Deductible per Benefit Period	
If you have single coverage:	$150
If you have family coverage:	$300
Non-PPO Network Deductible per Benefit Period	
If you have single coverage:	$150
If you have family coverage:	$300
PPO Network Coinsurance Limit per Benefit Period	
If you have single coverage:	$0
If you have family coverage:	$0
Non-PPO Network Coinsurance Limit per Benefit Period	
If you have single coverage:	$0
If you have family coverage:	$0
Deductible and Coinsurance Limit Processing (1)	Embedded

Deductible accumulations are separate.

You may be charged more than one Copayment per visit if multiple types of examinations are performed.

It is important that you understand how the claims administrator, 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 PERIOD MAXIMUMS PER COVERED PERSON	
Chiropractic Visits	12 visits
Outpatient Occupational and Physical Therapy Services	40 visits (combined)
Outpatient Speech Therapy Services	20 visits
Routine Mammogram Services	One mammogram; 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.

COINSURANCE PAYMENTS	Institutional and Professional Charges	Institutional Charges and Professional Charges
TYPE OF SERVICE	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 (2)
ALL COVERED SERVICES ARE SUBJECT TO THE DEDUCTIBLE, UNLESS "NOT SUBJECT TO THE DEDUCTIBLE" IS SPECIFICALLY STATED.		
EMERGENCY SERVICES		
Emergency - Emergency Room - the Institutional charge for use of the Emergency Room	$100 Copayment, waived if admitted, not subject to the Deductible	
Emergency Services - all other related Institutional charges and Emergency Room Physician's charges	0%, not subject to the Deductible	
Non-Emergency - Emergency Room - the Institutional charge for use of the Emergency Room	$100 Copayment, waived if admitted, not subject to the Deductible	
Non-Emergency Services - Emergency Room Physician's charges	0%, not subject to the Deductible	
INPATIENT SERVICES		
Semi-Private Room and Board	0%	30%
MENTAL HEALTH CARE, DRUG ABUSE AND ALCOHOLISM SERVICES		
Mental Health Care, Drug Abuse and Alcoholism Services	Any applicable Deductible, Coinsurance Limit 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).	
PHYSICIAN/OFFICE SERVICES		
Immunizations	0%	Not Covered
Medically Necessary Office Visits	0%	30%
Urgent Care Provider Office Visits	0%, not subject to the Deductible	30%
ROUTINE, PREVENTIVE AND WELLNESS SERVICES		
Child Health Supervision Office Visits and Immunizations	0%	Not Covered
Child Health Supervision Laboratory Services	0%	
Routine Chest X-ray, Complete Blood Count (CBC), Comprehensive Metabolic Panel, Electrocardiogram (EKG) and Urinalysis (UA)	0%	
Routine Colonoscopy	0%, not subject to the Deductible	30%
Routine Mammograms	0%	
Routine Pap Tests	0%	
Routine Physical Examinations (Age 18 and over)	0%	Not Covered

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SURGICAL SERVICES		
Inpatient and Outpatient Surgery	0%	30%
OTHER SERVICES		
Home Health Care Services	0%	Not Covered
Hospice Services	0%	Not Covered
Organ Transplant Services	0%	Not Covered
Outpatient Allergy Testing and Treatment Services	0%	Not Covered
Outpatient Medically Necessary Laboratory Services, Medical Tests and X-rays	0%	
All Other Covered Services	0%	30%

Notes

1. Under "Embedded processing," the Deductible applicable to single coverage must first be satisfied for at least one Covered Person within a family before Covered Services are payable for that Covered Person. After the Deductible has been met for that Covered Person, the Coinsurance Limit applicable to single coverage would then apply. Before Covered Services become payable for any other covered Dependents, the Deductible applicable to family coverage must be satisfied. After the family Deductible has been met, the Coinsurance Limit applicable to family coverage would then apply.

2. The Coinsurance percentage will be the same for Non-Contracting Providers as Non-PPO Network Providers but you may still be subject to balance billing and/or Excess Charges. Payments to Contracting Non-PPO Network Providers are based on Allowed Amount. Payments to Non-Contracting Providers are based on the Non-Contracting Amount.