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 other Providers who are outside of the PPO Network or who are 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 Allowed 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 Provider Hospital in an emergency.

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

PPO NETWORK COMPREHENSIVE MAJOR MEDICAL BENEFIT	
PPO Network Provider Deductible per Benefit Period	
If you have single coverage:	$100
If you have family coverage:	$200
Non-PPO Network Provider Deductible per Benefit Period	
If you have single coverage:	$200
If you have family coverage:	$400
PPO Network Provider Coinsurance Limit per Benefit Period	
If you have single coverage:	$500
If you have family coverage:	$1,000
Non-PPO Network Provider Coinsurance Limit per Benefit Period	
If you have single coverage:	$1,000
If you have family coverage:	$2,000
PPO Network Provider Out-of-Pocket Maximum per Benefit Period (Includes Deductibles, Copayments, and Coinsurance)	
If you have single coverage:	$600
If you have family coverage:	$1,200
Non-PPO Network Provider Out-of-Pocket Maximum per Benefit Period (Includes Deductibles, Copayments, and Coinsurance)	
If you have single coverage:	$1,200
If you have family coverage:	$2,400
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 (1)	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. If the Out-of-Pocket Maximum is unlimited, you continue to be responsible for paying the amounts shown above.

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 will also be applied to your Non-PPO Network Deductible or Non-PPO Network Coinsurance Limit. Any amounts applied to your Non-PPO Network Deductible or Non-PPO Network Coinsurance Limit will also be applied to your PPO Network Deductible or PPO Network Coinsurance Limit.

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)	
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
Routine Chest X-ray, Complete Blood Count (CBC), Comprehensive Metabolic Panel, Electrocardiogram (EKG) and Urinalysis (UA)	One each
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.
Routine Pap Tests and Associated Examinations	One test One examination (Age 21 and over)
Routine Physical Examinations (Age 21 and over)	Males - One examination Females - Two examinations

COINSURANCE PAYMENTS	Institutional and Professional Charges	Institutional 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)**
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	10%	
All other related Institutional charges and Emergency Room Physician's charges for an Emergency Medical Condition	10%	
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%
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)		
Immunizations	10%	20%
Medically Necessary Office Visits	10%	20%

COINSURANCE PAYMENTS	Institutional and Professional Charges	Institutional 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)
IF A DEDUCTIBLE APPLIES, ALL COVERED SERVICES ARE SUBJECT TO THE DEDUCTIBLE, UNLESS "NOT SUBJECT TO THE DEDUCTIBLE" IS SPECIFICALLY STATED.		
ROUTINE, PREVENTIVE AND WELLNESS SERVICES		
Preventive Services in accordance with state and federal law (3) (Please refer to the "Routine, Preventive and Wellness Services" benefit in this Benefit Book for more information.)	0%, not subject to the Deductible	20%
Routine Colonoscopy and Sigmoidoscopy (Age 50 and over) (4)	0%, not subject to the Deductible	20%
Routine Chest X-ray, Complete Blood Count (CBC), Comprehensive Metabolic Panel, Electrocardiogram (EKG) and Urinalysis (UA)	0%, not subject to the Deductible	20%
Routine Mammograms	0%, not subject to the Deductible	20%
Routine Pap Tests and Associated Examinations	0%, not subject to the Deductible	20%
Routine Physical Examinations (Age 21 and over)	0%, not subject to the Deductible	20%
Routine Prostate Specific Antigen (PSA) Tests	0%, not subject to the Deductible	20%
Well Child Care Services (Under age 21)	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. "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 Out-of-Pocket Maximum for single coverage shown on the Schedule of Benefits.

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

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

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

DEFINITIONS

After Hours Care - services received in a Physician's office at times other than regularly scheduled office hours, including days when the office is normally closed (e.g., holidays or Sundays).

Agreement - the administrative services agreement between Medical Mutual and your Group. The Agreement includes the individual Enrollment Forms of the Card Holders, this Benefit Book, Schedules of Benefits and any Riders or addenda.

Alcoholism - a Condition classified as a mental disorder and described in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) or the most recent version, as alcohol dependence, abuse or alcoholic psychosis.

Allowed Amount - For PPO Network and Contracting Providers, including Pharmacies, the Allowed Amount is the lesser of the applicable Negotiated Amount or Covered Charge. For Non-Contracting Providers, including non-Network Pharmacies, the Allowed Amount is the Non-Contracting Amount, which will likely be less than the Billed Charges.

Autotransfusion - withdrawal and reinjection/transfusion of the patient's own blood; only the patient's own blood is collected on several occasions over time to be reinfused during an operative procedure in which substantial blood loss is anticipated.

Benefit Book - this document.

Benefit Period - the period of time specified in the Schedule of Benefits during which Covered Services are rendered, and benefit maximums, Deductibles, and Out-of-Pocket Maximums are accumulated. The first and/or last Benefit Periods may be less than 12 months depending on the effective date and the date your coverage terminates.

Billed Charges - the amount billed on the claim submitted by the Provider for services and supplies provided to a Covered Person.

Birth Year - a 12 month rolling year beginning on the individual's birth date.

Card Holder - an Eligible Employee or member of the Group who has enrolled for coverage under the terms and conditions of the Plan and persons continuing coverage pursuant to COBRA or any other legally mandated continuation of coverage.

Charges - the Provider's list of charges for services and supplies before any adjustments for discounts, allowances, incentives or settlements. For a Contracting Hospital, charges are the master charge list uniformly applicable to all payors before any discounts, allowances, incentives or settlements.

Coinsurance - a percentage of the Allowed Amount or Non-Contracting Amount for which you are responsible after you have met your Deductible or paid your Copayment, if applicable.

Coinsurance Limit - a specified dollar amount of Coinsurance expense Incurred in a Benefit Period by a Covered Person for Covered Services.

Condition - an injury, ailment, disease, illness or disorder.

Contraceptives - oral, injectable, implantable or transdermal patches for birth control.

Contracting - the status of a Provider:

- that has an agreement with Medical Mutual or Medical Mutual's parent company about payment for Covered Services; or
- that is designated by Medical Mutual or its parent as Contracting.

Copayment - a dollar amount, if specified in the Schedule of Benefits, that you may be required to pay at the time Covered Services are rendered.

Covered Charges - the Billed Charges for Covered Services, except that Medical Mutual reserves the right to limit the amount of Covered Charges for Covered Services provided by a Non-Contracting Provider to the Non-Contracting Amount determined as payable by Medical Mutual.

Covered Person - the Card Holder, and if family coverage is in force, the Card Holder's Eligible Dependent(s).

Covered Service - a Provider's service or supply as described in this Benefit Book for which the Plan will provide benefits, as listed in the Schedule of Benefits.

Custodial Care - care that does not require the constant supervision of skilled medical personnel to assist the patient in meeting their activities of daily living. Custodial Care is care which can be taught to and administered by a lay person and includes but is not limited to:

- administration of medication which can be self-administered or administered by a lay person; or
- help in walking, bathing, dressing, feeding or the preparation of special diets.

Custodial Care does not include care provided for its therapeutic value in the treatment of a Condition.

Custodian - a person who, by court order, has permanent custody of a child.

Deductible - an amount, usually stated in dollars, for which you are responsible each Benefit Period before the Plan will start to provide benefits.

Drug Abuse - a Condition classified as a mental disorder and described in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) or the most recent version, as drug dependence abuse or drug psychosis.

Emergency Medical Condition - a medical Condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing an individual's health in serious jeopardy, or with respect to a pregnant woman, the health of the woman or her unborn child;
- Result in serious impairment to the individual's bodily functions; or
- Result in serious dysfunction of a bodily organ or part of the individual.

Emergency Services - a medical screening examination as required by federal law that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to Stabilize the patient.

Enrollment Form - a form you complete for yourself and your Eligible Dependents to be considered for coverage under the Plan.

Essential Health Benefits - benefits defined under federal law (PPACA) as including benefits in at least the following categories; ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Refer to the Schedule of Benefits and the Health Care Benefits section of this Benefit Book to identify which of these Essential Health Benefits are included in this plan.

Excess Charges - the difference between Billed Charges and the applicable Allowed Amount or Non-Contracting Amount. You may be responsible for Excess Charges when you receive services from a Non-Contracting Provider or a non-Network Pharmacy.

Experimental or Investigational Drug, Device, Medical Treatment or Procedure - a drug, device, medical treatment or procedure is Experimental or Investigational:

- if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is provided; or
- if reliable evidence shows that the drug, device, medical treatment or procedure is not considered to be the standard of care, is the subject of ongoing phase I, II or III clinical trials, or is under study to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis; or
- if reliable evidence shows that the consensus of opinion among experts is that the drug, device, medical treatment or procedure is not the standard of care and that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence may consist of any one or more of the following:

- published reports and articles in the authoritative medical and scientific literature;
- opinions expressed by expert consultants retained by Medical Mutual to evaluate requests for coverage;
- the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure;