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. See "Eligibility" for optional extension to age 28.

PPO NETWORK COMPREHENSIVE MAJOR MEDICAL BENEFIT	
PPO Network Provider Deductible per Benefit Period	
If you have single coverage:	$6,350
If you have family coverage:	$12,7000
Non-PPO Network Provider Deductible per Benefit Period	
If you have single coverage:	$10,000
If you have family coverage:	$20,000
PPO Network Provider Coinsurance Limit per Benefit Period	
If you have single coverage:	$0
If you have family coverage:	$0
Non-PPO Network Provider Coinsurance Limit per Benefit Period	
If you have single coverage:	$5,000
If you have family coverage:	$10,000
PPO Network Provider Out-of-Pocket Maximum per Benefit Period (Includes Deductibles, Copayments, and Coinsurance)	
If you have single coverage:	$6,350
If you have family coverage:	$12,700
Non-PPO Network Provider Out-of-Pocket Maximum per Benefit Period (Includes Deductibles, Copayments, and Coinsurance)	
If you have single coverage:	$15,000
If you have family coverage:	$30,000
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.

The Deductible, Coinsurance Limit and Out-of-Pocket Maximum that applies to PPO Network Providers accumulates separately from the Deductible, Coinsurance Limit and Out-of-Pocket Maximum that applies to Non-PPO Network Providers and Non-Contracting Providers.

It is important that you understand how Medical Mutual calculates your responsibilities under this Certificate. 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 (up to age 14) • Speech and Language Therapy • Occupational Therapy • Clinical Therapeutic Intervention	 20 visits 20 visits 20 hours per week
Chiropractic/Spinal Manipulation Visits	12 visits
Home Health Care Services	100 visits
Inpatient Physical Medicine and Rehabilitation Services	60 days
Outpatient Cardiac Rehabilitation Services	36 visits
Outpatient Occupational Therapy Services	20 visits
Outpatient Physical Therapy Services	20 visits
Outpatient Pulmonary Therapy Services	20 visits
Outpatient Speech Therapy Services	20 visits
Routine 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.
Routine Pap Tests	One test
Skilled Nursing Facility Services	90 days

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 (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	0%	
All other related Institutional charges and Emergency Room Physician's charges for an Emergency Medical Condition	0%	
INPATIENT SERVICES		
Maternity	0%	40%
Physical Medicine and Rehabilitation	0%	40%
Semi-Private Room and Board	0%	40%
Skilled Nursing Facility	0%	40%
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).	
PHYSICIAN/OFFICE SERVICES (includes Mental Health and Substance Abuse Disorders)		
Immunizations	0%, not subject to the Deductible	40%
Medically Necessary Office Visits	0%	40%
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 Certificate for more information.)	0%, not subject to the Deductible	40%
Routine Colonoscopy and Sigmoidoscopy (Ages 40-75)	0%, not subject to the Deductible	40%
Routine Anoscopy and Proctosigmoidoscopy (all ages) and Routine Colonoscopy and Sigmoidoscopy (other than ages 40-75)(4)	0%, not subject to the Deductible	40%
Routine Laboratory, X-ray and Medical Testing Services	0%, not subject to the Deductible	40%
Routine Mammograms	0%, not subject to the Deductible	40%
Routine Pap Tests	0%, not subject to the Deductible	40%

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 (2)**
IF A DEDUCTIBLE APPLIES, ALL COVERED SERVICES ARE SUBJECT TO THE DEDUCTIBLE, UNLESS "NOT SUBJECT TO THE DEDUCTIBLE" IS SPECIFICALLY STATED.		
Routine Physical Examinations (Age 21 and over)	0%, not subject to the Deductible	40%
Well Child Care Services (Under age 21)	0%, not subject to the Deductible	40%
SURGICAL SERVICES		
Inpatient Surgery	0%	40%
Medically Necessary Endoscopic Procedures (i.e, Colonoscopy, Sigmoidoscopy, etc.)	0%	40%
Outpatient Surgery	0%	40%
OTHER SERVICES		
All Other Covered Services	0%	40%

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. For plan year 2018 the self-only Out-of-Pocket Maximum is $7,350.
2. 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 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.

PRESCRIPTION DRUG BENEFIT

Prescription Drug Covered Services are subject to any Comprehensive Major Medical Benefit Period Deductible and Out-of-Pocket Maximum shown in the Comprehensive Major Medical Schedule of Benefits.

Specialty Prescription Drugs are covered under this benefit when obtained through Medical Mutual's preferred specialty pharmacy and are limited to a maximum of a thirty (30) day supply. Specialty Prescription Drugs require prior approval from Medical Mutual.

Maximum Days' Supply	90 days for retail Prescription Drugs 30 days for Specialty Prescription Drugs 90 days for Home Delivery Prescription Drugs

RETAIL PHARMACY BENEFIT - UP TO A 30 DAY SUPPLY (1)	
TYPE OF SERVICE	**For Covered Services, you pay the following portion, based on the Allowed Amount**
Generic Prescription Drugs	0%
Brand Name Prescription Drugs	0%
Prescribed Generic Prescription Drug Contraceptives or Brand Name Prescription Drug Contraceptives when an equivalent Generic Prescription Drug Contraceptive is not available	0%, not subject to the Deductible
Preventive Prescription Drugs and Vaccines in accordance with state and federal law.	0%, not subject to the Deductible
Prescription Drugs received from non-Network Pharmacies	You pay the entire amount at the Pharmacy and file a claim form with Medical Mutual. Medical Mutual will reimburse you based on the Allowed Amount, minus the Prescription Drug Copayment or Coinsurance, as indicated. You may be responsible for any amount in excess of the Prescription Drug Covered Charges. If the Prescription Drug is not available from a Network Pharmacy, you will not be subject to this reduced reimbursement.

CONTRACTING HOME DELIVERY PHARMACY BENEFIT - 90 DAY SUPPLY (1)	
TYPE OF SERVICE	**For Covered Services received from a CONTRACTING Home Delivery Pharmacy, you pay the following portion, based on the Allowed Amount**
Generic Prescription Drugs	0%
Brand Name Prescription Drugs	0%
Prescribed Generic Prescription Drug Contraceptives or Brand Name Prescription Drug Contraceptives when an equivalent Generic Prescription Drug Contraceptive is not available	0%, not subject to the Deductible
Preventive Prescription Drugs and Vaccines in accordance with state and federal law.	0%, not subject to the Deductible

Coverage is provided for Contracting Home Delivery Pharmacies only. Services received from any Non-Contracting Home Delivery Pharmacy are excluded.

Prescription Drug Notes

1. This plan does not provide coverage or impose cost sharing for a prescribed, orally administered cancer medication on a less favorable basis than the coverage it provides or cost sharing it imposes for intravenously administered or injected cancer medications.