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:	$1,000
If you have family coverage:	$2,000
Non-PPO Network Provider Deductible per Benefit Period	
If you have single coverage:	$1,000
If you have family coverage:	$2,000
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:	$500
If you have family coverage:	$1,000
PPO Network Provider Out-of-Pocket Maximum per Benefit Period (Includes Deductibles, Copayments, and Coinsurance)	
If you have single coverage:	$1,000
If you have family coverage:	$2,000
Prescription Drug Benefit Out-of-Pocket Maximum	
If you have single coverage:	$5,600
If you have family coverage:	$11,200
Total PPO Network Provider Out-of-Pocket Maximum, including Prescription Drug Covered Charges	
If you have single coverage:	$6,600
If you have family coverage:	$13,200
Non-PPO Network Provider Out-of-Pocket Maximum per Benefit Period (Includes Deductibles, Copayments, and Coinsurance)	
If you have single coverage:	Unlimited
If you have family coverage:	Unlimited
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 will also be applied to your Non-PPO Network Deductible. Any amounts applied to your Non-PPO Network Deductible will also be applied to your PPO Network Deductible.

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

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)	
Chiropractic/Spinal Manipulation Visits	24 visits
Home Health Care Services	60 visits
Inpatient Physical Medicine and Rehabilitation Services	60 days
Medically Necessary and Routine Invitro Fertilization and Artificial Insemination	$10,000
Outpatient Institutional Cardiac Rehabilitation Services	50 visits
Outpatient Institutional Pulmonary Therapy Services	50 visits
Outpatient Occupational Therapy Services	50 visits
Outpatient Physical Therapy Services	50 visits
Outpatient Professional Cardiac Rehabilitation Services	50 visits
Outpatient Professional Pulmonary Therapy Services	50 visits
Outpatient Speech Therapy Services	50 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	60 days

MAXIMUM LIFETIME BENEFIT PER COVERED PERSON	
Hospice Services	360 days

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	$125 Copayment, waived if admitted, not subject to the Deductible	
All other related Institutional charges and Emergency Room Physician's 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**	$125 Copayment, waived if admitted, not subject to the Deductible	$125 Copayment, waived if admitted, then 20%, not subject to the Deductible
Emergency Room Physician's Charges in a **non-emergency**	0%, not subject to the Deductible	20%, not subject to the Deductible
INPATIENT SERVICES		
Maternity	0%	20%
Physical Medicine and Rehabilitation	0%	20%
Semi-Private Room and Board	0%	20%
Skilled Nursing Facility	0%	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 • Professional and Institutional	$15 Copayment, not subject to the Deductible (3)	20%
Chiropractic Services	$15 Copayment, not subject to the Deductible (3)	20%
Occupational Therapy Services	$15 Copayment, not subject to the Deductible (3)	20%
Physical Therapy Services	$15 Copayment, not subject to the Deductible (3)	20%
Pulmonary Therapy Services • Professional and Institutional	$15 Copayment, not subject to the Deductible (3)	20%
Speech Therapy Services	$15 Copayment, not subject to the Deductible (3)	20%
PHYSICIAN/OFFICE SERVICES (includes Mental Health and Substance Abuse Disorders)		
Immunizations	0%, not subject to the Deductible	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.		
Medically Necessary Office Visits	$15 Copayment, not subject to the Deductible (3)	20%
Urgent Care Office Visits	$20 Copayment, not subject to the Deductible	
ROUTINE, PREVENTIVE AND WELLNESS SERVICES		
Preventive Services in accordance with state and federal law (4) (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 (Ages 40-75)	0%, not subject to the Deductible	20%
Routine Anoscopy and Proctosigmoidoscopy (all ages) and Routine Colonoscopy and Sigmoidoscopy (other than ages 40-75) (5)	0%, not subject to the Deductible	20%
Routine Hearing Examinations (Age 21 and over)	0%, not subject to the Deductible	20%
Routine Laboratory, X-ray and Medical Testing Services	0%, not subject to the Deductible	20%
Routine Mammograms	0%, not subject to the Deductible	20%
Routine Pap Tests	0%, not subject to the Deductible	20%
Routine Physical Examinations (Age 21 and over)	0%, not subject to the Deductible	20%
Routine Vision Examinations (Age 21 and over)	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	0%	20%
Medically Necessary Endoscopic Procedures (i.e, Colonoscopy, Sigmoidoscopy, etc.)	0%	20%
Outpatient Anesthesia and Assistant Surgeon Services when performed in a Physician's office	0%, not subject to the Deductible	20%
Outpatient Surgery when performed in a Physician's office	$15 Copayment, not subject to the Deductible (3)	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.		
Surgical Services performed in all other places of service	0%	20%
OTHER SERVICES		
Ambulance Services	0%	
Dental Services for an Accidental Injury	0%	
Durable Medical Equipment and Medical Supplies when received in a Physician's Office	0%, not subject to the Deductible	20%
IUD Devices	0%, not subject to the Deductible	20%
Outpatient Allergy Testing and Treatment Services	0%, not subject to the Deductible	20%
Outpatient Medically Necessary Laboratory Services, Medical Tests and X-rays	0%, not subject to the Deductible	20%
Therapeutic Injections when performed in a Physician's Office	0%, not subject to the Deductible	20%
All Other Covered Services	0%	20%

Comprehensive Major Medical 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 Out-of-Pocket Maximum 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 Out-of-Pocket Maximum applicable to family coverage would then apply.
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. If any of these Covered Services are received on the same day, only one $15 Copayment will be charged per day.
4. 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.
5. 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 Out-of-Pocket Maximum shown in the Comprehensive Major Medical Schedule of Benefits. However, if a Brand Name Prescription Drug is purchased when a Generic Prescription Drug is available and medically appropriate (as determined by the Covered Person's Physician), the difference between the cost of the Generic and Brand Name Prescription Drug that the Covered Person pays is not counted toward the Out-of-Pocket Maximum.

Prescription Drug Out-of-Pocket Maximum If you have single coverage If you have family coverage	 $5,600 $11,200
Days Supply	30 days for retail Prescription Drugs or 90 days for Home Delivery Prescription Drugs

The following Prescription Drugs are not subject to a Prescription Drug Copayment each time services are received from a Participating Drug Provider or a Contracting Home Delivery Pharmacy:

- Prescribed Generic Prescription Drug Contraceptives or Brand Name Prescription Drug Contraceptives when an equivalent Generic Prescription Drug Contraceptive is not available.
- preventive care vaccines, including immunizations for flu and shingles (i.e., Zostavax)
- diabetic supplies including over-the-counter supplies[1], glucomonitors and glucometers
- immunizations, vaccines and biologicals

RETAIL PHARMACY BENEFIT - UP TO A 30 DAYS SUPPLY

TYPE OF SERVICE	For Covered Services, you pay the following portion, based on the Allowed Amount
Generic Prescription Drugs	$5 Copayment
Preferred Brand Name Prescription Drugs for which a Generic Prescription Drug is not available or manufactured	$10 Copayment
Preferred Brand Name Prescription Drugs for which a Generic Prescription Drug is available or manufactured (2)	$5 Copayment plus the difference between the cost of the Generic Prescription Drug and the cost of the Brand Name Prescription Drug
Non-Preferred Brand Name Prescription Drugs for which a Generic Prescription Drug is not available or manufactured	$20 Copayment
Non-Preferred Brand Name Prescription Drugs for which a Generic Prescription Drug is available or manufactured (2)	$5 Copayment plus the difference between the cost of the Generic Prescription Drug and the cost of the Brand Name Prescription Drug
Preventive Prescription Drugs and Vaccines in accordance with state and federal law.	$0 Copayment
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 for 75% of the Allowed Amount, minus the Prescription Drug Copayment 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.

[1] Over-the-counter supplies require a Prescription Order.

CONTRACTING HOME DELIVERY PHARMACY BENEFIT - 90 DAYS SUPPLY	
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	$5 Copayment
Preferred Brand Name Prescription Drugs for which a Generic Prescription Drug is not available or manufactured	$10 Copayment
Preferred Brand Name Prescription Drugs for which a Generic Prescription Drug is available or manufactured (2)	$5 Copayment plus the difference between the cost of the Generic Prescription Drug and the cost of the Brand Name Prescription Drug
Non-Preferred Brand Name Prescription Drugs for which a Generic Prescription Drug is not available or manufactured	$20 Copayment
Non-Preferred Brand Name Prescription Drugs for which a Generic Prescription Drug is available or manufactured (2)	$5 Copayment plus the difference between the cost of the Generic Prescription Drug and the cost of the Brand Name Prescription Drug
Preventive Prescription Drugs and Vaccines in accordance with state and federal law.	$0 Copayment

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

Prescription Drug Notes

1. Over-the-counter supplies/drugs require a Prescription Drug Order.
2. If your Physician prescribes a Brand Name Prescription Drug and indicates this drug is to be dispensed as written (DAW), you will only be required to pay the Brand Name Prescription Drug Copayment.

PPO NETWORK MAJOR MEDICAL HEALTH CARE BENEFIT BOOK

This Benefit Book describes the health care benefits available to you as a Covered Person in the Self Funded Health Benefit Plan (the Plan) offered to you by your Employer or your Union (the Group). This is not a summary plan description by itself. However, it may be attached to or included with a document prepared by your Group that is called a summary plan description.

There is an Administrative Services Agreement between Medical Mutual Services, LLC (Medical Mutual) and the Group pursuant to which Medical Mutual processes claims and performs certain other duties on behalf of the Group.

All persons who meet the following criteria are covered by the Plan and are referred to as **Covered Persons, you or your.** They must:

- pay for coverage if necessary; and
- satisfy the Eligibility conditions specified by the Group.

The Group and Medical Mutual shall have the exclusive right to interpret and apply the terms of this Benefit Book. The decision about whether to pay any claim, in whole or in part, is within the sole discretion of Medical Mutual, subject to any available appeal process.

This Benefit Book is not a Medicare Supplement Benefit Book. If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from Medical Mutual.