MEDICAL MUTUAL OF OHIO
GROUP CONTRACT

This Contract is entered into between _____ (called the Group or Employer) and **Medical Mutual of Ohio** ("Medical Mutual"). This Contract supersedes any contracts previously entered into by and between the Group and Medical Mutual and its predecessors.

This Contract is made in consideration of the Group application and individual applications, which are incorporated in and made a part of this Contract by reference, and the payment of premiums when due, and is subject to the terms and conditions of the Certificates, Schedules of benefits, riders, Amendments and addenda, which are incorporated in and made a part of this Contract by reference.

Based on this consideration, Medical Mutual agrees with the Group to provide to all eligible Covered Persons, the Covered Services described in the Certificates, Schedules of benefits, riders and Amendments listed in Addendum II of this Contract beginning on each Covered Person's Effective Date.

The Contract Date is _____. The Contract Period shall be from the Contract Date through _____ when, unless canceled or terminated as provided by this Contract, or the Group's rating class or funding arrangement changes, this Contract will renew for a further period of twelve (12) consecutive months and thereafter, from year to year. Renewal may be subject to changes in rates and Contract terms.

Medical Mutual will maintain copies of this Contract, including any exhibits or attachments, in electronic form, and copies reproduced from such electronic forms or any other reliable means (for example: photocopy, image or facsimile) shall in all respects be considered equivalent to an original. An electronic signature shall be deemed a valid signature for all purposes under this Contract.

IN WITNESS WHEREOF, Medical Mutual hereby accepts the Group Application at its address stated in the Group Application, and Medical Mutual and the Group have signed this Contract to be effective on the Contract Date first above written.

_____	**MEDICAL MUTUAL OF OHIO**
(The Group)	**(Medical Mutual)**
_____	_____
SIGNATURE	SIGNATURE
_____	_____
TITLE	TITLE
_____	_____
DATE	DATE

ARTICLE I - DEFINITIONS

Section 1.1 **Amendment** - a document which alters this Contract.

Section 1.2 **Application** - all forms required by Medical Mutual to determine the eligibility of Covered Persons.

Section 1.3 **Certificate(s)** - the document(s) that describe(s) Covered Services and for whom Covered Services are payable. Schedules of benefits, riders and Amendments may be included as part of the Certificate.

Section 1.4 **Certificate Holder** - an Eligible Employee or member of the Group who has been approved and accepted by Medical Mutual and who has enrolled for coverage under the terms and conditions of this Contract.

Section 1.5 **Contract** - these pages and the Group Application individual Applications, Certificates, Schedules of benefits, riders, Amendments and addenda.

Section 1.6 **Covered Person** - the Certificate Holder, and if two-person or family coverage is in force, the Certificate Holder's Eligible Dependent(s).

Section 1.7 **Covered Service** - a Provider's service, supply, or accommodation described in a Covered Person's Certificate, Schedule of benefits, riders or Amendments for which Medical Mutual pays.

Section 1.8 **Effective Date** - 12:01 a.m. on the date coverage begins for a Covered Person as determined by Medical Mutual.

Section 1.9 **Eligible Dependent** - an Eligible Person other than the Certificate Holder, as defined in the Certificate or Schedule of benefits, riders or Amendments.

Section 1.10 **Eligible Employee** - a member of the Group who receives a wage or salary from the Group, as reported on the Group's federal and state payroll reports, and who, in accordance with Medical Mutual's underwriting guidelines, is eligible to be a Covered Person under the terms and conditions of this Contract.

Section 1.11 **Eligible Person** - a person approved by Medical Mutual in accordance with Medical Mutual's underwriting guidelines, who is eligible to be a Covered Person under the terms and conditions of this Contract.

Section 1.12 **Group (Employer)** - employer, labor union, collective bargaining unit, trust, partnership, department, or other organization which, pursuant to this Contract, provides group health care benefits to its eligible and enrolled employees or members.

Section 1.13 **Medicare** - the program of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Section 1.14 **Provider** - a Hospital, Other Facility Provider, Physician or Other Professional Provider as stated in the Certificate, Schedules of benefits, riders and Amendments.

ARTICLE II - ELIGIBILITY AND ENROLLMENT

Section 2.1 Eligibility

Only the following persons may be Eligible Persons under this Contract:

(a) Active, full-time employees, officers or partners of the Group, working thirty (30) or more hours per week.

(b) Retired employees under 65 years of age, if retiree coverage is provided by the Group, who meet all of the following criteria:

(i) length of service with the Employer plus age must be sixty (60) or more years;

(ii) continuous service of thirty (30) or more hours a week with the Employer for five (5) or more consecutive years prior to retirement;

(iii) continuous enrollment in the Employer's group health insurance program for five (5) or more consecutive years prior to retirement.

(c) Persons whose compensation is reported on Form 1099, rather than Form W-2, may be covered if ALL of the following criteria are met:

(i) The employee works at least thirty (30) hours per week exclusively for the Employer.

(ii) The Employer's contribution toward the employee's premium is equal to that for all other Eligible Employees.

(iii) The Employer makes coverage available to all current and future employees meeting the same criteria.

(iv) A minimum of fifty percent (50%) of the Group's enrolled employees are taxed employees.

(d) Eligible participants of an employee welfare benefit trust or collective bargaining unit, trade or professional association if such entity is the Group.

(e) Covered Persons entitled to continuation of coverage under applicable state and federal laws, who are notified according to those laws, and make elections within the grace periods specified, and continue to make the required contributions in a timely manner as specified.

(f) A Certificate Holder's Eligible Dependents.

(g) Employees on short or long-term disability if such employees were covered by the previous carrier and appear on the billing of the previous carrier and are covered by a disability plan that precludes individual selection.

(h) Dependent children who, in accordance with Ohio Revised Code 3923.24 are eligible for continuation coverage beyond the limiting age.

(i) Persons for whom the Employer is required to maintain or reinstate coverage according to the terms of the Family and Medical Leave Act P.L. 103-3.

Section 2.2 Ineligible Persons

Persons ineligible under this Contract include without limitation the following: part-time employees working less than the number of hours specified in Section 2.1, independent contractors, except as specified in Section 2.1(c) above, temporary employees, seasonal employees who do not meet the requirements for full-time coverage established by the Affordable Care Act, employees who are laid off, and any individuals who do not meet the requirements for eligibility according to the terms of the Certificate, Schedules of benefits, riders or Amendments.

Section 2.3 Newly Eligible Persons

The Employer may add new persons to the group of persons initially enrolled. Before qualifying for enrollment, any new person must complete an Application that is submitted to and accepted by Medical Mutual. The Group must give notice to Medical Mutual of a new person's eligibility status within thirty-one (31) days after the date that the person becomes eligible. If Medical Mutual does not receive notice of the new person's eligibility status within thirty-one (31) days after the person becomes eligible, addition of the new person will be subject to Section 2.6(d).

Section 2.4 Verification of Eligibility and Changes in Eligibility

(a) The Group must provide Medical Mutual with all information required by Medical Mutual to determine a person's eligibility under this Contract.

(b) The Group must provide Medical Mutual with written notice of termination of a person's eligibility under this Contract within thirty-one (31) days of the change. Written notice by the Group to Medical Mutual of changes in a person's eligibility must be furnished in writing or electronically on forms and/or in a format approved by Medical Mutual.

(c) The Group acknowledges that a Covered Person cannot be retroactively canceled, except in the limited instances of fraud and intentional misrepresentation. In some situations, when an individual pays no premium (including COBRA premium) following termination of eligibility, the Group may be permitted to terminate coverage retroactively to the date of the loss of eligibility. The time periods for such retroactive terminations may be limited and, in many circumstances, coverage will only be able to be terminated prospectively. If the Group fails to provide notice to Medical Mutual within 31 days of the date when a Covered Person ceases to be eligible under the Plan and, as a result, Medical Mutual incurs claims costs that would otherwise not have been paid due to the person's ineligibility, the Group shall be liable to Medical Mutual for all such claim payments made by Medical Mutual. The Group's liability for such claim payments shall continue until the date the Group notifies Medical Mutual of the change in eligibility.

(d) Effective Dates for Covered Persons under this Contract are conditioned upon the receipt of all information required by Medical Mutual to determine a person's eligibility.

Section 2.5 Re-certification

Upon request by Medical Mutual, the Group shall deliver to Medical Mutual a letter or other document of assurance, signed by an authorized person of the Group, certifying that the Group has complied with and continues to meet all regulations required of the Group by Medical Mutual. The Group shall also promptly deliver to Medical Mutual all information requested by Medical Mutual to assure the continuing eligibility of Covered Persons and compliance with the terms of the contract.

Section 2.6 Enrollment

(a) The Group agrees that to be approved and enrolled by Medical Mutual, all employees and members of the Group must enroll through electronic means or complete individual Applications.

(b) The Group agrees that all Eligible Persons may enroll for coverage under this Contract.

(c) During the enrollment process, the Group agrees to inform and explain this Contract to all Eligible Persons of the Group.

(d) If the Group does not enroll an Eligible Person within thirty-one (31) days of that person becoming eligible, as required by Section 2.6(a), that person must wait to enroll until the Group's next annual open enrollment period.

(e) **Group Health Plan Special Enrollment:** An Eligible Employee or eligible dependent who has declined the coverage provided by this Contract may enroll for coverage under this Contract during any special enrollment period if coverage is lost, or an eligible dependent is added, for the following reasons, as well as for any other event that may be added by federal regulations.

1. In order to qualify for special enrollment rights because of loss of coverage, the Eligible Employee or dependent must have had other group health plan coverage at the time coverage under this Contract was previously offered, and the Eligible Employee signed a written waiver at the time of initial eligibility declining coverage for himself or his dependent(s) due to the existence of the other coverage.

   a. If coverage under the other group health plan was non-COBRA, loss of eligibility or contributions by the employer toward that plan must end. A loss of eligibility for special enrollment includes:

      i. Loss of eligibility for coverage as a result of divorce, legal separation or termination of Domestic Partnership
      ii. Cessation of dependent status, such as attaining the maximum age to be eligible as a dependent child under the plan
      iii. Death of an eligible employee
      iv. Termination of employment
      v. Reduction in the number of hours of employment that results in a loss of eligibility for plan participation (including a strike, layoff or lock-out)
      vi. Loss of coverage that was one of multiple health insurance plans offered by an employer, and the Eligible Employee elects a different plan during an open enrollment period
      vii. An individual no longer resides, lives, or works in an HMO Service Area (whether or not within the choice of the individual), and no other benefit package is available to the individual through the other employer
      viii. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual
      ix. A situation in which an individual incurs a claim that would meet or exceed a medical plan lifetime limit on all benefits
      x. Termination of an employee's or dependent's coverage under Medicaid or under a state child health insurance plan (CHIP)
      xi. The Eligible Employee or dependent is determined to be eligible for premium assistance in the Group's plan under a Medicaid or CHIP plan

   b. If the Eligible Employee or dependent has COBRA coverage, the coverage must be exhausted in order to trigger a special enrollment right.

c. Enrollment must be supported by written documentation of the termination of the other coverage with the effective date of said termination stated therein. Other than for termination of Medicaid or CHIP coverage or eligibility for premium assistance under these programs, notice of intent to enroll must be provided to Medical Mutual by the Group no later than thirty (30) days following the triggering event described above, with coverage to become effective on the date the other coverage terminated. For termination of Medicaid or CHIP coverage or eligibility for premium assistance under Medicaid or a CHIP plan, notice of intent to enroll must be provided to Medical Mutual by the Group within sixty (60) days following the triggering event, with coverage to become effective on the date of the qualifying event. If Medical Mutual does not receive written notice of intent to enroll within the thirty (30) or sixty (60) day periods described herein, addition of the Eligible Person will be subject to Section 2.6(d).

2. If an Eligible Employee acquires a new dependent as a result of marriage, Declaration of Domestic Partnership, birth, adoption or placement for adoption, the Eligible Employee may be permitted to enroll himself and his dependents, provided that Medical Mutual receives the request for enrollment within thirty (30) days after the marriage, Declaration of Domestic Partnership, birth, adoption or placement for adoption.

3. If an Eligible Employee acquires a new dependent as a result of entering into a Domestic Partnership, there is no special enrollment period. Newly acquired Domestic Partners may only be added during open enrollment.

Section 2.7 Enrollment Levels

The Group agrees to meet or exceed the enrollment requirements specified in Addendum I which is incorporated in and made a part of this Contract by reference.

ARTICLE III - CERTIFICATES AND EFFECTIVE DATES OF COVERAGE

Section 3.1 Certificates and Summaries of Benefits and Coverage.

Medical Mutual will provide the Group with applicable Certificates, Schedules of Benefits, riders and Amendments describing the Covered Services, how benefits are paid and claim filing instructions. Medical Mutual will also provide the Group with Summaries of Benefits and Coverage, as required by the Affordable Care Act. It is the responsibility of the Group to deliver each of these documents to the Group's Certificate Holders and, with respect to the Summary of Benefits and Coverage, to any covered dependent known to reside at an address different from the Certificate Holder's last known address.

The Certificates, Schedule of benefits, riders and Amendments listed in Addendum II are incorporated in and made a part of this Contract by reference and may be modified according to the terms of this Contract and applicable law.

Medical Mutual will prepare a Summary of Benefits and Coverage document (SBC) on behalf of the Group. On and after the Effective Date of this coverage, the responsibility for distribution of the SBC to Certificate Holders will be as follows:

(a) If the Group has made or elected a change to the benefits provided under this policy since its application for coverage, Medical Mutual will distribute an SBC to the Certificate Holders at the same time that identification cards are issued.

(b) At the time Medical Mutual provides the Group with its renewal materials, it will also provide the Group with an SBC for each plan option currently offered by the Group. The Group must distribute the appropriate SBC with its open enrollment material to the Certificate Holders. If the Group does not require an open enrollment or annual election for coverage, the SBC must be distributed to the Certificate Holders no later than thirty (30) days prior to the Renewal Date.

(c) If, in conjunction with its renewal, the Group makes a change to any plan option that affects the content of the SBC, Medical Mutual will prepare a revised SBC and will distribute the SBC to Certificate Holders no later than seven (7) business days following the issuance of the revised Certificate.

(d) If no benefit changes affecting the content of the SBC are made at renewal, Medical Mutual will prepare and distribute an SBC to Certificate Holders within seven (7) business days of the Renewal Date.

(e) If the Group initiates a material modification to benefits that affects the content of the SBC, Medical Mutual will prepare the SBC, and the Group must distribute the SBC to the Certificate Holders. If Medical Mutual of Ohio makes a material modification to benefits that affects the content of the SBC, Medical Mutual will prepare and distribute the SBC to the Certificate Holders. In either event, the SBC must be distributed to the Certificate Holders no later than sixty (60) days prior to the effective date of the material modification.

(f) Certificate Holders who have enrolled for coverage may request a copy of an SBC at any time. Medical Mutual will provide such SBC within seven (7) business days of receipt of the request. Eligible Employees or Members who have not enrolled for coverage may request an SBC from the Group. The Group must provide the SBC within seven (7) business days of such a request.

Section 3.2 Identification Cards

Medical Mutual will provide the Group with identification cards. It is the responsibility of the Group to deliver identification cards to Certificate Holders. The receipt and/or possession of an identification card does not automatically entitle the Covered Person to benefits. The identification cards are the property of Medical Mutual and must be surrendered to Medical Mutual upon request. The Group shall be liable for claims incurred through the use of an identification card by a person whose coverage has been canceled or terminated if the Group has not provided Medical Mutual with written notice pursuant to Section 2.4(b). Further use of the identification card by a person whose coverage has been canceled or terminated may subject that person to legal action.

Section 3.3 Dates of Coverage

(a) For Eligible Persons enrolled during the Group's initial enrollment period, coverage starts on the Contract Date.

(b) For a newly Eligible Person enrolled after this Contract Date, coverage starts as of his or her date of eligibility, provided Medical Mutual has received such person's Application within thirty-one (31) days of the date of eligibility.

(c) For an Eligible Person enrolled pursuant to Section 2.6(d), coverage starts on the first day of the month following acceptance by Medical Mutual.

ARTICLE IV - PAYMENTS

Section 4.1 Premium Payments

(a) The Group shall be liable to Medical Mutual or an agent designated by Medical Mutual for the payment of any premium as well as any fees associated with late payment and insufficient funds.

(b) The initial premium must be received by Medical Mutual on or before the Contract Date.

(c) Premium payments are due on the first day of each month. This is called the Premium Due Date, and all premiums must be paid on or before the Premium Due Date. If premium payments are not received within ten (10) days of the Premium Due Date, Medical Mutual reserves the right to assess a late fee of $39.

(d) If a check written, or electronic payment made, by the Group is returned to Medical Mutual by the Group's financial institution for insufficient funds, Medical Mutual reserves the right to charge the Group a returned item fee up to the maximum allowed by applicable law. This fee is in addition to any fees charged to the Group by the Group's financial institution and any late fees imposed as referenced Section 4.1 (c).

(e) A period of thirty-one (31) days from the Premium Due Date is allowed for the payment of premiums and required fees, except the initial and renewal premiums. During the thirty-one (31) day period this Contract will stay in force; however, the payment of claims by Medical Mutual may be suspended until all required premiums and fees are received by Medical Mutual and late fees may be imposed as referenced in 4.1(c).

(f) This Contract will be in force only so long as premiums and any required fees are paid. In the event of non-payment, the Group must notify in writing all of its Certificate Holders of termination of this Contract.

(g) In the event all required premium and fee payments are not received by Medical Mutual within thirty-one (31) days after the Premium Due Date, this Contract may be terminated by Medical Mutual retroactively to the last day of the period for which premiums and any required fees were paid.

(h) The amount of premiums payable under this Contract for the Contract Period is specified in Addendum III which is incorporated in and made a part of this Contract by reference. Premium and fee payments made when due will keep this Contract in force from the Premium Due Date to the next Premium Due Date.

(i) All Covered Persons entitled to continuation of coverage under applicable state and federal laws and who elect the coverage within the time frame specified in those laws, will be charged the full premium plus the administrative fee surcharge (where applicable) allowed under those laws.

(j) This Contract may be renewed on the anniversary day of the Contract Date. This is called the Premium Renewal Date. All renewal premiums must be paid on or before the Premium Renewal Date. Renewal premiums not paid when due may subject the Group to termination of coverage as defined in Section 6.1 of the Contract.

(k) Because a reduction in the Group's premium contribution can impact the Plan's grandfathered status, the Group must notify Medical Mutual if its contribution toward the cost of coverage decreases at any time by more than five percent (5%) below the contribution rate in effect on March 23, 2010.

(l) The Group or Medical Mutual may be subject to taxes, fees or other charges imposed on Medical Mutual by state or federal government laws or regulations. To the extent permitted by law, Medical Mutual will include such charges, or an estimate of such charges if the actual amount is not known, in the premiums charged to the Group or may show them as a separate line item on the Group's invoice. Medical Mutual reserves the right to adjust the premium or monthly billing to the Group during the Contract Period in order to accommodate the payment of such fees, taxes or other charges.

(m) The premium rates set forth on Addendum III assume that Medical Mutual has been made aware of all underlying plans in effect that will either partially or completely subsidize any member cost sharing including, but not limited to, copays, deductibles and/or coinsurance balances. Medical Mutual reserves the right to change the premiums on a retroactive basis if Medical Mutual has not been notified of the existence of an underlying cost-sharing subsidy plan.

(n) For any rebate due and payable as a consequence of the medical loss ratio ("MLR") requirements of the Patient Protection and Affordable Care Act ("PPACA") and/or applicable state law, all such rebates paid shall constitute a return of premium. Upon receipt of the rebate, the Group shall refund to each Certificate Holder his or her proportional share of the rebate as may be required by applicable law. Upon reasonable request, the Group shall provide to Medical Mutual documentation as required by law of the distribution of the rebate to Certificate Holders. The Group agrees to provide such documentation within the time frame designated by Medical Mutual.

In the event of a claim related to the amount of the Certificate Holder's rebate, the Group shall cooperate with Medical Mutual and provide Medical Mutual with information required to investigate the claim. If Medical Mutual is required to pay additional amounts to a Certificate Holder due to the Group's failure to either: (1) provide accurate information to Medical Mutual; or (2) make a refund of the appropriate rebate amount due to the Certificate Holder, then the Group agrees to reimburse Medical Mutual for such additional amount paid by Medial Mutual to the Certificate Holder. This provision shall survive the termination of the Contract.

Section 4.2 Change in Premiums

Medical Mutual may change the amount of premiums for this Contract. Medical Mutual shall give at least thirty (30) days notice of the change in premium prior to the Premium Due Date. Changes in premium rates will be conclusively determined to have been approved by the Group if the Group pays the required premium.

ARTICLE V - UNIFORM PROVISIONS

Section 5.1 Notice of Claim and Proof of Loss

Written or electronically submitted proof of loss must be furnished to Medical Mutual in accordance with the applicable Certificate. Proof must be given within ninety (90) days of Covered Services being received or as soon as is reasonably possible. In no event, except in the absence of legal capacity, may proof be submitted later than one (1) year or the time specified in the Group Certificate after the Covered Service has been received.

Section 5.2 Time of Payment of Claims

Covered Services under this Contract will be paid within thirty (30) days after receipt of a properly completed claim accompanied by sufficient documentation reasonably required by Medical Mutual to accept or reject the claim. To have a claim payment or claim denial reviewed, the Covered Person must request a review by Medical Mutual within six (6) months of the claim determination.

If the Group fails to comply with the requirements under applicable state and federal laws regarding continuation of coverage, Medical Mutual will not accept liability and will return any claims received from Covered Persons to the Group.

Section 5.3 Legal Actions

No action at law or in equity shall be brought to recover on this Contract prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Contract. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Section 5.4 Statute of Limitations

In the case of legal action between the parties to this Contract, no such action may be brought more than three (3) years from the date the cause of action arises, or it will be deemed time-barred and waived. The parties waive any statute of limitations to the contrary.

Section 5.5 Entire Contract

The entire Contract between Medical Mutual and the Group contains these pages and the Group Application, individual Applications, Certificates, Schedule of benefits, riders, Amendments and addenda. This Contract shall be made available for inspection at the office of the Group during regular business hours.

Section 5.6 Fraudulent Statements and Conduct

All statements, in the absence of fraud, made by the Group or any Covered Person shall be deemed representations and not warranties. No statement shall void the coverage or reduce the benefits of this Contract unless contained in a written Application attached hereto.

Medical Mutual shall have the right to void a Covered Person's coverage if that person engages in fraudulent conduct relating to an Application or to a claim for Covered Services or for the use of an identification card.

ARTICLE VI - TERMINATION

Section 6.1 Termination

The Group may cancel or terminate this Contract only upon thirty (30) days' advance written notice to Medical Mutual. Medical Mutual may cancel or terminate this Contract at any time without notice if the Group fails to pay the required premiums, including renewal premiums, or other required fees. Medical Mutual's negotiation of any check sent or deposited into Medical Mutual's lockbox after the termination date does not constitute acceptance or reinstatement by Medical Mutual.

Medical Mutual may cancel or terminate this Contract at any time by giving notice in writing to the Group at least thirty (30) days prior to the effective date of termination for the following reasons:

(a) For fraud or misrepresentation by the Group;

(b) The Group fails or ceases to meet the requirements specified in Addendum I; or

(c) For breach of any Contract provisions approved by the Superintendent of Insurance, including the failure to execute this Contract for a period longer than sixty (60) days following its effective date.

If this Contract is canceled or terminated pursuant to Article VI, the Group must notify in writing all of its Certificate Holders of the cancellation or termination, except as stated below in the event of a discontinuance and replacement or an exit from the small group market in Ohio.

In the event Medical Mutual discontinues offering a particular plan under this Contract, defined as a "discontinuance and replacement" under the Affordable Care Act's guaranteed renewability provisions, Medical Mutual will provide ninety (90) days' notice to the Group and to each Certificate Holder prior to the discontinuance and replacement.

If Medical Mutual ceases to offer coverage in the small group market in Ohio, Medical Mutual will provide one-hundred eighty (180) days' notice to the Group and to each Certificate Holder prior to the expiration of this coverage.

Section 6.2 Liability for Premiums and Fees Upon Termination

If this Contract is canceled or terminated by Medical Mutual or the Group, the Group shall be liable for all premiums and fees due to Medical Mutual, up to the date of cancellation or termination, or Medical Mutual shall refund to the Group the amount of unearned premiums actually paid by the Group in advance of the termination date; provided the Group has given notice as required by Section 6.1. Medical Mutual shall not refund fractional amounts which represent unearned premiums for less than one (1) month, nor any income earned on the refund amounts.

Section 6.3 Liability of Medical Mutual Upon Termination

No benefits will be paid by Medical Mutual for any expenses incurred or treatment received after termination of this Contract except for Covered Services specified as payable after termination in the applicable Certificate.

Section 6.4 Termination of a Covered Person's Coverage

(a) Medical Mutual may terminate a Covered Person's coverage under this Contract upon notice to the Covered Person:

(1) When the Covered Person makes a material misrepresentation to the group health plan or to Medical Mutual;

(2) When the Covered Person has furnished any fraudulent information or statements including fraudulent claims to Medical Mutual;

(3) When the Covered Person has permitted his or her identification card to be used by another; or

(4) When a Covered Person intentionally fails to comply with the terms of the plan which have been approved by the Superintendent of Insurance for the state of Ohio.

(b) A Covered Person's coverage will also terminate:

(1) When a Covered Person ceases to be eligible under Article II;

(2) When any required premiums for the Covered Person are not paid. (the person's coverage terminates at the end of the last period for which payment was made);

(3) When the Certificate Holder no longer resides, lives or works within the Service Area (or in an area in which Medical Mutual is licensed to do business); or

(4) When this Contract terminates. In that event, the coverage of all Covered Persons automatically terminates without notice, except as provided in Section 6.3 of this Contract.

(c) A Covered Person who is entitled to continuation of coverage under applicable state and federal laws and who has elected to continue coverage within the specified time periods will also have his or her coverage terminated if:

(1) The Covered Person becomes entitled to Medicare;

(2) Any required premiums for the Covered Person are not paid;

(3) When the Covered Person no longer resides, lives or works within the Service Area (or in an area in which Medical Mutual is licensed to do business);

(4) The Covered Person has reached the permitted maximum period of continuation;

(5) This Contract terminates; or

(6) The Covered Person fails to comply with any other statutory requirements.

ARTICLE VII - COVERAGE AND RIGHTS

Section 7.1 Medical Mutual as Payor

Nothing in this Contract shall have the effect of imposing upon Medical Mutual any obligation to provide any Covered Service, but only to make payments to Providers or Certificate Holders for Covered Services in consideration of the premiums paid by the Group under this Contract and Addendum III hereto.

Section 7.2 Employee Retirement Income Security Act of 1974, as amended (ERISA)

The parties agree that Medical Mutual, when performing its obligations under this Agreement, is not the plan sponsor or plan administrator as those terms are defined in the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Medical Mutual agrees to be the named fiduciary for the purposes of administering claims and hearing appeals of adverse benefit determinations only. It is the responsibility of the Group to inform Covered Persons of their ERISA-mandated rights and to comply with any responsibilities, obligations, duties and notifications imposed upon the Plan Administrator by ERISA.

Section 7.3 Consolidated Omnibus Budget Reconciliation Act, As Amended (COBRA)

It is the responsibility of the Employer to inform Covered Persons of their COBRA mandated rights according to the provisions of COBRA and to comply with all COBRA requirements outlined in applicable federal laws.

Pursuant to a contract between Medical Mutual and its contracted COBRA administrator the Group agrees to utilize the services of the COBRA administrator to provide COBRA notifications and other COBRA administrative services.

Section 7.4 Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Group shall be responsible for providing any HIPAA-required notices.

Section 7.5 Change of Covered Services

Medical Mutual may change or revise the Covered Services provided through this Contract. The Group will be given at least sixty (60) days' notice prior to the effective date of a material change. If the Group makes the required payment it is conclusively determined that all Covered Persons of the Group have accepted the changes. It is the Group's responsibility to notify its Certificate Holders of these changes and the effective date thereof.

Section 7.6 Coordination of Benefits

Coordination of benefits will be administered in accordance with the terms set forth in the Certificate(s) and Ohio law.

Section 7.7 Waiver of Contractual Rights

Failure by Medical Mutual to insist on or enforce any of its rights shall not constitute a waiver of those rights by Medical Mutual, and nothing shall constitute a waiver of Medical Mutual's rights to insist on strict compliance with the provisions of this agreement.

Section 7.8 Retention of Discretion

Medical Mutual shall have the exclusive right to interpret the terms of the Certificate, Schedule of benefits, riders and Amendments. The decision about whether to pay any claim, in whole or in part, is within the sole discretion of Medical Mutual and such decisions shall be final and conclusive, subject to any appeals process as outlined in the Certificate. If, however, the Group requires by exception that Medical Mutual pay for services that Medical Mutual determines are outside the scope of the terms of the Contract, the Group agrees to reimburse Medical Mutual for such payment(s) and any related administrative costs.

ARTICLE VIII - AUDITS AND RECORDS

Section 8.1 Cost Recovery Audits

Medical Mutual may perform random cost recovery audits that do not relate to any specific group. Any amounts recovered by Medical Mutual as a result of the audit will be used to offset the cost of the audit. Amounts recovered in excess of the cost of the audit will be retained by Medical Mutual unless there is an adjustment to a specific claim. If there is such an adjustment, it will be reflected in the Group's claims history. The cost of the recovery will be subtracted from the adjustment.

Section 8.2 Review of Records

The Group's payroll records may be audited by Medical Mutual for information related to eligibility, participation levels and Employer contributions.

The Group agrees to cooperate with Medical Mutual, its agents and employees in the investigation of any complaints of fraudulent conduct by any Covered Person. Such cooperation shall include, but not be limited to, review of records, claims, applications for insurance and any other documents relating to a Covered Person's enrollment with the Group.

ARTICLE IX - MISCELLANEOUS

Section 9.1 Contract Changes

No change in this Contract will be effective until approved in writing by an authorized officer of Medical Mutual. This approval must be endorsed on or attached to this Contract. No agent, employee or representative of Medical Mutual, other than an authorized officer, may change this Contract or waive any of its provisions.

Section 9.2 Amendments

The terms and conditions of this Contract may be amended by Medical Mutual at any time with 30 days notice to the Group. The amendment will be deemed to have been agreed to by the Group if the Group pays the next required premium. It is the responsibility of the Group to notify Certificate Holders of any changes in the terms or conditions of this Contract.

Section 9.3 Notice

Any notice required under this Contract must be in writing. Notice to the Group must be hand-delivered, or mailed by first-class mail with proper postage, to the Group at the Group's address stated in the Group Application. Notice to Medical Mutual must be hand-delivered, or mailed by first-class mail with proper postage, to Medical Mutual at Medical Mutual's address stated in the Group Application. Notice shall be deemed effectively received on the date of delivery or three (3) days after the date of post mark, whichever is earlier.

Either the Group or Medical Mutual may, by written notice, indicate a new notice address.

Medical Mutual has the right, at its option and discretion, to communicate with Covered Persons about matters relating to this Contract, or Certificates, Schedules of Benefits and any riders or Amendments.

Section 9.4 Indemnification

Medical Mutual and the Group shall perform their respective duties under this Contract in a prudent and diligent manner. The Group shall indemnify Medical Mutual for and hold it harmless against all liabilities, claims, costs and expenses (including court costs and reasonable attorney's fees) incurred by Medical Mutual in defending itself against any claims, actions or proceedings arising out of, or related in any way to, the Group's failure to perform its duties or obligations under this Contract in a prudent and diligent manner.

Section 9.5 Provider Discounts; Refunds

Medical Mutual negotiates agreements with Providers. These negotiations are undertaken on behalf of Medical Mutual and not on behalf of the Group. These negotiations and agreements are not a function Medical Mutual has undertaken or will undertake pursuant to this Contract, and Medical Mutual and the Group acknowledge that Medical Mutual is not a fiduciary when performing this function.

The Group is obligated to pay the premiums specified in Article IV, and Medical Mutual shall have no right to any additional amounts from the Group. Medical Mutual is obligated to pay for Covered Services pursuant to this Contract, and the Group shall have no right to any additional amounts from Medical Mutual.

Some of Medical Mutual's contracts with Providers, including Institutional Providers, allow discounts, allowances, incentives, adjustments and settlements. These amounts are for the benefit of Medical Mutual, and Medical Mutual will retain any payments resulting therefrom. However, the deductibles, coinsurance and benefit maximums will be calculated based on the Allowed Amount as described in the Certificate. In addition, pursuant to Ohio Revised Code Section 3923.81, if a policy has a high deductible or savings account feature, claims paid under that policy will also be paid according to the Allowed Amount.

Medical Mutual has and retains the right to choose which Providers and other vendors it will contract with, and on what terms and to amend and terminate those contracts. Medical Mutual has and retains the right to designate Providers as contracting, SuperMed and/or network.

Section 9.6 Cost Management Programs

The Group agrees to cooperate with Medical Mutual and network Providers in Medical Mutual's cost and utilization management programs which Medical Mutual implements from time to time, such as pre-admission certification, concurrent review, case management and other carrier liability programs.

The Group shall inform Covered Persons enrolled in any Medical Mutual network program of the requirements of that program and assist Medical Mutual in implementing such requirements, including, but not limited to, financial disincentives for failure to use a network Provider for non-emergency inpatient or outpatient services. The Group shall not do anything to change the financial disincentives set forth in the Certificate and will not take any other actions which discourage Covered Persons from utilizing network providers.

Section 9.7 Employer Shared Responsibility

The Group understands that if it is an applicable large employer, as defined in the Affordable Care Act and its regulations, the Group may be subject to a penalty if the coverage it provides is not affordable or does not provide minimum value, as required by federal law.

Section 9.8 Maximum Waiting Period

The Group agrees that, in accordance with the Affordable Care Act and its regulations, it shall not impose any waiting period for new employees that exceeds ninety (90) days.

Section 9.9 Severability

If any provision or any part or any application of this Contract is for any reason held to be illegal or invalid, such illegality or invalidity shall not affect or impair any other provision or right or remedy of Medical Mutual.

Section 9.10 Governing Law

This Contract shall be governed by and construed in accordance with the laws of the state of Ohio.

Ohio Guaranty Association Notice

The Ohio Life and Health Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Ohio. You should not rely on coverage by the Ohio Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy. Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. You should check with your insurance company representative to determine if you are only covered in part or not covered at all.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

Ohio Life and Health Insurance Guaranty Association
1840 Mackenzie Drive
Columbus, Ohio 43220

Ohio Department of Insurance
50 W. Town Street
Third Floor, Suite 300
Columbus, Ohio 43215

Group Application

Application is hereby made to Medical Mutual of Ohio (called Medical Mutual) whose home office address is 2060 East Ninth Street, Cleveland, Ohio 44115, by _____ (called the Group or Employer) whose main office address is, _____ for the coverage afforded by Group Number _____, the terms of which are hereby approved and accepted by the Group to take effect on the Contract Date specified in the Group Contract.

The Group hereby appoints as its proxy, to act for and on its behalf at any and every annual meeting and special meeting of the members of Medical Mutual of Ohio, the person who is Secretary of such corporation at the time of such annual or special meetings, as the case may be, with power of substitution, and empowers such proxy to vote and act for and on behalf of the Group at each such meeting as fully and to the same extent as the Group could do if personally represented thereat. This proxy shall continue in force until ten years from the date hereof unless sooner revoked by a writing signed by the Group and delivered to Medical Mutual.

It is agreed that this application supersedes any previous applications for this Group Contract.

It is further agreed that the approval and acceptance of this Group Application and individual Applications is subject to Medical Mutual's underwriting guidelines.

This Group Application is not a contract for health care benefits. The mere completion of this Group Application does not obligate Medical Mutual to pay for any health care benefits. Medical Mutual shall not be obligated to pay for health care benefits unless and until this Group Application is accepted in writing by an authorized officer of Medical Mutual.

Signed by_____

Title_____
(Authorized Signature for the Group)

On _____, 20_____

Witness_____

WARNING: Any person who with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)

Addendum I

Minimum Enrollment and Contribution Requirements

1. It is understood that this Contract will not be issued outside of the specified open enrollment period or renewed unless the Group enrolls the minimum number of Eligible Employees, as specified below, after the exclusions for "2(a)" through "2(f)" below are made. At least 75% of the net Eligible Employees must be covered under this Contract.

2. In determining the Group's minimum enrollment, Medical Mutual will also exclude any employee who waives coverage under this plan only if the employee is enrolled:
    a. in a spouse's employer-sponsored health plan;
    b. as an active Eligible Employee or Retiree in another health plan sponsored by a second employer;
    c. covered under a parent's plan;
    d. covered by Medicare and/or a Medicare supplement plan; or
    e. in a government-sponsored plan, such as TRICARE, Medicaid, or Veteran's Administration (VA) coverage; or
    f. in subsidy-eligible individual coverage.

3. The Group's minimum contribution must be 50% of the premium for each Certificate Holder, including each retiree, but excluding any Certificate Holder continuing coverage under this plan, as allowed by state or federal law.

4. A minimum of 75% of the Certificate Holders must reside in the State of Ohio.

5. The Group agrees not to enter into any other group health care contract, or sponsor any other program on behalf of its employees for health care benefits, other than an HMO program.

6. The Group must have a corporate headquarters in Ohio. If not headquartered in Ohio, Medical Mutual can sign a contract for an Ohio location or division.

7. If a Group drops below minimum enrollment, participation, or contribution requirements, this Contract may be terminated by Medical Mutual.