



**MEDICAL MUTUAL OF OHIO GROUP CONTRACT**

This Contract is entered into between \_\_\_\_\_  
(called the Group or Employer) and **Medical Mutual of Ohio** (called 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, individual applications and Medical History Questionnaires (MHQ), 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.

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.

\_\_\_\_\_  
**(The Group)**

**MEDICAL MUTUAL OF OHIO**  
**(Medical Mutual)**

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
TITLE

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## ARTICLE I - DEFINITIONS

- Section 1.1**      **Amendment** - a document which alters this Contract.
- Section 1.2**      **Application** - all questionnaires and 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(s).
- 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, Medical History Questionnaires, Certificates, Schedule 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:
  - (i) for Groups of 50 or fewer, working 25 or more hours per week.
  - (ii) for groups of 51 or more, working \_\_\_\_ or more hours per week. (May not be less than 20 hours per week)
- (b) For groups of 51 or more only, retired employees, 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 twenty (20) or more hours a week or 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) Eligible participants of an employee welfare benefit trust or collective bargaining unit, trade or professional association if such entity is the Group.
- (d) 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.
- (e) A Certificate Holder's Eligible Dependents.
- (f) 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.
- (g) Dependent children who, in accordance with Ohio Revised Code 3923.24 are eligible for continuation of coverage beyond the limiting age.
- (h) 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, temporary employees, seasonal employees (unless such employees work at least nine (9) months in a consecutive twelve (12) month period), employees who are laid off, retirees of groups with 50 or fewer eligible employees, and any individuals who do not meet the requirements for eligibility according to the terms of the Certificate(s), 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 submit an application and a Medical History Questionnaire (for Groups of 50 or fewer eligible employees) and be approved and accepted by Medical Mutual. The Group must give notice to Medical Mutual of a new person's eligible 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), except for newborn children or children placed for adoption. The addition of a newborn or child placed for adoption to a single or two-person contract will result in a change to a two-person or a family contract.

## **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 any change in a person's eligibility under this Contract within thirty-one (31) days of the change. If the Group fails to provide such notice, the person will be subject to the provisions of Section 2.6 (d). Written notice by the Group to Medical Mutual of changes in a person's eligibility must be furnished on forms approved by Medical Mutual.
- (c) The Group shall be liable to Medical Mutual for payments by Medical Mutual for Covered Services provided to an ineligible person where the Group has failed to give prompt written notice of the person's change in eligibility.
- (d) The Group's claims experience shall include the cost of services for ineligible, canceled or terminated persons for which the Group failed to notify Medical Mutual in writing of changes in the persons' eligibility.
- (e) 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 accepted and enrolled by Medical Mutual, all employees and members of the Group must complete individual Applications. Medical History Questionnaires are also required from:

- i. Groups Size 1-50 - all employees or members
- ii. Groups Size 51-99 - employees or members who enroll more than thirty one (31) days after their dates of eligibility or qualifying events.

Medical History Questionnaires will not be used to reject any Eligible Employee or dependent. However, Medical History Questionnaires may be used to evaluate and change the Group's rates, as provided pursuant to Section 4.2, if the Group's level of risk changes significantly.

- (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 submit an Application for 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 Groups next annual open enrollment period. In addition, Medical Mutual may impose an eighteen (18) month pre-existing condition waiting period, as permitted by federal law, beginning on the earlier of the effective date or the first day of any waiting period imposed by the Group. Claims for newborn children, children placed for adoption and maternity are excluded from any applicable pre-existing condition waiting period.
- (e) An Eligible Employee or dependent who has declined the coverage provided by this Contract may enroll for coverage under this contract during any special enrollment period if the following conditions are met:
- (1) The employee or dependent was covered under another group health plan or had other health insurance at the time of initial eligibility;
  - (2) 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.

- (3) The employee or dependent was covered under COBRA continuation coverage and such coverage was exhausted; or the employee or dependent loses eligibility for the coverage due to death, divorce, legal separation, termination of employment, termination of employer contributions for the coverage, termination of employment in a class eligible for coverage, reduction in hours of employment resulting in a loss of coverage, the exhaustion of any applicable lifetime benefit package option, coverage is provided through an HMO and the employee or dependent no longer works or lives in the HMO's service area (and there is no other coverage available under the plan), or the plan no longer offers coverage to a class of similarly situation individuals which includes the employee or dependent.

Enrollment must be supported by written documentation of the termination of the other coverage with the effective date of said termination stated therein. Notice of intent to enroll must be provided to Medical Mutual by the Group no later than thirty-one (31) days following the triggering event described in (e)(3) with coverage to become effective on the date the other coverage terminated. If Medical Mutual does not receive written notice of intent to enroll within thirty-one days (31), addition of the Eligible Person will be subject to Section 2.6(d).

### **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**

The Certificates, Schedules of benefits, riders and Amendments listed in Addendum II are incorporated in and made a part of this Contract by reference.

Certificates, Schedules of benefits, riders and Amendments may be canceled or added during the term of this Contract.

Medical Mutual will provide the Group with applicable Certificates, Schedules of benefits, riders and Amendments that describe the Covered Services and to whom payable, together with claim filing instructions. It is the responsibility of the Group to deliver the applicable Certificates, Schedules of benefits, riders and Amendments to Certificate Holders.

### **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. Whenever a Covered Person's coverage is canceled or terminated, the Group shall make every effort to collect the identification card and return it to Medical Mutual. The Group shall be liable for claims incurred through the use of an identification card not properly collected by the Group 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 the 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.
- (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) A period of thirty (30) days from the Premium Due Date is allowed for the payment of premiums, except the initial and renewal premiums. During the thirty (30) day period this Contract will stay in force; however, the payment of claims by Medical Mutual may be suspended until the premiums are received by Medical Mutual and late fees may be imposed as referenced in 4.1 (c).
- (e) This Contract will be in force only so long as premiums are paid. The Group must notify in writing all of its Certificate Holders of termination of this Contract due to non-payment of premiums.
- (f) In the event the premiums are not received by Medical Mutual within thirty (30) days after the Premium Due Date, this Contract may be terminated by Medical Mutual retroactive to the last day of the period for which premiums were paid.
- (g) The amount of the 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. A premium payment made when due will keep this Contract in force from the paid due date of the premium to the next Premium Due Date.

All Covered Persons entitled to continuation of coverage under applicable state and federal laws, 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.

- (h) 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's termination of coverage as defined in Section 6.1 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 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 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 review in writing to 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 Limitation of Actions**

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. 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. In the case of legal action other than those to recover benefits, no such action may be brought more than two (2) years from the date the cause of action arises.

#### **Section 5.4 Entire Contract**

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

GROUP NO: \_\_\_\_\_  
FORM NO: CCX07007

99 AND UNDER FULLY INSURED CONTRACT

### **Section 5.5 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 days 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. 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;
- (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; or
- (d) Medical Mutual ceases to offer coverage in the small group market.

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.

### **Section 6.2 Liability for Premiums Upon Termination**

If this Contract is canceled or terminated by Medical Mutual or the Group, the Group shall be liable for all premiums 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 refunded 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 incorrect or incomplete information regarding a Covered Person has been furnished in an Application to Medical Mutual that affects the acceptance of an Application and induces Medical Mutual to enter into this Contract, set rates or premiums or to provide payment for Covered Services that otherwise would not have been done, including any medical history questions which are part of an Application;
  - (2) When the Covered Person has furnished 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; or
  - (3) When this Contract terminates, 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 has elected to continue coverage within the specified time periods, will also have his or her coverage terminated if:
  - (1) The Covered Person becomes covered as an employee or otherwise under another group health plan that does not contain an exclusion or limitation with respect to any pre-existing condition of that Covered Person;
  - (2) The Covered Person becomes entitled to Medicare; or
  - (3) Any required premiums for the Covered Person are not paid; or
  - (4) 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 Contract, is not an administrator, plan sponsor or a named or unnamed fiduciary as those terms are defined in ERISA. In performing its obligations under this Contract, Medical Mutual is a fiduciary, as that term is defined by ERISA and to the extent allowed by ERISA, only for the purpose of processing claims. It is the responsibility of the Employer to inform Covered Persons of their ERISA mandated rights and to comply with any ERISA mandated responsibilities, obligations or duties for the Group.

### **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 the 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 1986 (HIPAA)**

- (a) Medical Mutual will provide certificates of creditable coverage to individuals losing coverage under the Plan. Medical Mutual will provide such certificates only while this Contract is in force. If this Contract is terminated, no certificates will be issued by Medical Mutual except as requested by Covered Persons or the Group.
- (b) Except as provided in Paragraph 7.4(a), it is the responsibility of the Group to provide any other notices required by HIPAA.

### **Section 7.5 Change of Covered Services**

Medical Mutual may change or revise the Covered Services provided through this Contract at any time. The Group will be given at least thirty (30) days notice prior to the effective date of the 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 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 7.7 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 - COORDINATION OF BENEFITS**

**Section 8.1 General**

- (a) This coordination of benefits (COB) provision applies to This Plan when an employee or the employee’s covered dependent has health care coverage under more than one Plan. “Plan” and “This Plan” are defined below for purposes of this Article VIII.
- (b) If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:
  - (1) Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but
  - (2) May be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. The above reduction is described in Section 8.4 “Effect on the Benefits of This Plan.”

**Section 8.2 Definitions**

- (a) “Plan” means any of the following which provides benefits or services for, or because of, medical or dental care or treatment:
  - (1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
  - (2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).
  - (3) “Plan” does not include school accident-type coverage or some supplemental sickness and accident policies.

Each Contract or other arrangement for coverage under (1) or (2) is a separate plan. If an arrangement has two parts and COB rules apply to only one of the two, each part is a separate Plan.

- (b) “This Plan” is the part of this group contract that provides benefits for health care expenses.

- (c) “Primary Plan/Secondary Plan”: the order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan’s benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan’s benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan or Plans.

- (d) “Allowable Expense” means a necessary, reasonable and customary item of expense for health care when the item of expense is covered by This Plan. However, This Plan is not required to pay for an item, service, or benefit which is not a part of This Plan’s contract.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

### **Section 8.3 Order of Benefit Determination Rules**

- (a) When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan whose benefits are determined after those of the other Plan, unless:

- (1) The other Plan has rules coordinating its benefits with those of This Plan; and
- (2) Both those rules and This Plan’s rules, in subsection (b) below, require that This Plan’s benefits be determined before those of the other Plan.

- (b) This Plan determines its order of benefits using the first of the following rules which applies:

- (1) The benefits of the Plan which covers the person as an employee, member, insured, or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act, of 1965 and implementing regulations, Medicare is:

(A) Secondary to the Plan covering the person as a dependent and

(B) Primary to the Plan covering the person as other than a dependent (e.g., a retired employee).

- (2) Benefits for a dependent child whose parents are not separated or divorced shall be determined as follows:

(A) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

- (B) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which has covered the other parent for a shorter period of time.

However, if the other Plan does not have the rules described in (A) above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

- (3) To the extent the Plan has been notified by receiving a copy of the court decree, benefits for a dependent child whose parents are divorced or separated shall be determined as follows:

(A) If the specific terms of the court decree state that one of the parents is responsible for the health care expenses of the child, the benefits of the Plan of that parent are determined first. The Plan of the other parent shall be the Secondary Plan.

(B) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall be subject to the order of benefit determination contained in subdivision (b)(2) of this section.

If neither subdivision (A) nor (B) applies, the order of benefits shall be determined in the following order:

- i. The Plan of the parent with custody of the child;
- ii. The Plan of the spouse of the parent with custody of the child;
- iii. The Plan of the parent not having custody of the child; and
- iv. The Plan of the spouse of the parent not having custody of the child.

- (4) The benefits of a Plan which covers a person as an employee who is neither laid off, not retired (or as that employee's dependent) are determined before the benefits of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this paragraph shall be ignored.

- (5) Continuation Coverage - If a person whose coverage is provided under a right of continuation pursuant to federal law (i.e., COBRA) or state law also is covered under another Plan, the benefits of the Plan covering the person as an employee, member or subscriber (or that person's dependent) shall be determined before the benefits under the continuation coverage. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this paragraph shall be ignored.

- (6) Longer/shorter Length of Coverage - If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

**Section 8.4 Effect on the Benefits of This Plan**

- (a) This section applies when, in accordance with Section 8.3 “Order of Benefit Determination Rules,” This Plan is a Secondary Plan as to one or more other Plans. In that event, the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as “the other plans” in (b) below.
- (b) Reduction in This Plan’s benefits. The benefits of This Plan will be reduced to the extent that the sum of:
  - (1) The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
  - (2) The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses.

**Section 8.5 Right to Receive and Release Needed Information**

Certain facts are needed to apply these COB rules. Medical Mutual has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Medical Mutual need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Medical Mutual any facts it needs to pay the claim.

**Section 8.6 Facility of Payment**

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, Medical Mutual may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. Medical Mutual will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

**Section 8.7 Right of Recovery**

Subject to the restrictions contained in Ohio Revised Code Section 3901.388, if the amount of the payments made by Medical Mutual is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- 1. The persons it has paid or for whom it has paid;
- 2. Another Plan; or
- 3. The provider of service.

The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

## ARTICLE IX - AUDITS AND RECORDS

### Section 9.1 Cost Recovery Audits

Medical Mutual may perform random cost recovery audits which do not relate to any specific group. Any amounts recovered by Medical Mutual as a result of the audits will be used to offset the cost of the audits. 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 9.2 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 X - MISCELLANEOUS

### Section 10.1 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 10.2 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 10.3 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, Schedule of benefits and any riders or Amendments.

#### **Section 10.4     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 claims, actions or proceedings arising out of or related to in any way the Group's failure to perform its duties or obligations under this Contract in a prudent and diligent manner.

#### **Section 10.5     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 payment resulting therefrom. However, the deductibles, coinsurance and benefit maximums will be calculated based on the Lesser 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 Lesser 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 10.6     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 10.7     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 10.8    Governing Law**

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

**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 \_\_\_\_\_

ADDENDUM I

MINIMUM ENROLLMENT AND CONTRIBUTION REQUIREMENTS

1. It is understood that this Contract will not be issued or renewed unless the Group enrolls the minimum number of Eligible Employees as specified in the table below before the exclusions for 2(a) through (d) below are made.

| <u>Eligible Employees</u> | <u>Minimum Required to Enroll</u> |
|---------------------------|-----------------------------------|
| 4 or fewer                | All                               |
| 5+                        | 75%                               |

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; or
  - b) As an active Eligible Employee or as a Retiree in another health plan sponsored by a second employer.
  - c) Covered by a parent's health insurance plan.
  - d) Covered by Medicare and/or a Medicare Supplement plan.
3. Eligible Employees enrolled in another product option underwritten by Medical Mutual or its affiliated subsidiaries, will be included in the Group's minimum enrollment count. Eligible Employees enrolled in another product option not underwritten by Medical Mutual or its affiliated subsidiaries will be counted as eligible but will not be included in the Group's minimum enrollment count.
4. Active Eligible Employees who are also Medicare eligible will be included in the Group's minimum enrollment count. Retirees or persons continuing coverage as prescribed by state or federal law, will not be included in the Group's minimum enrollment count.
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. If a Group drops below minimum enrollment requirements, this Contract may be terminated by Medical Mutual.
7. The Group must contribute a minimum of twenty-five percent (25%) of the Group's total premium and must contribute a minimum of twenty-five percent (25%) toward the premium for each enrollee, including each retiree, but excluding any employee continuing coverage under this plan as allowed by state or federal law.