Class Action Lawsuit

MEDICAL MUTUAL OF OHIO

MERRIMAN LEGAL

IN THE COURT OF COMMON PLEAS
LORAIN COUNTY, OHIO

LORAIN COUNTY, OHIO
226 Middle Avenue
Elyria, Ohio 44035,

and

CITY OF ELYRIA, OHIO
131 Court Street
Elyria, Ohio 44035,

and

CITY OF LORAIN, OHIO
200 West Erie Avenue
Lorain, Ohio 44052,

and

On Behalf of Themselves and All Others Similarly Situated,

Plaintiffs,

vs.

MEDICAL MUTUAL OF OHIO
2060 East Ninth Street
Cleveland, Ohio 44115,
and

MEDICAL MUTUAL SERVICES, LLC
2060 East Ninth Street
Cleveland, Ohio 44115,

Defendants.

17 CV 191670

CASE NO.

JUDGE JUDGE RAYMOND J. EWERS

CLASS ACTION COMPLAINT FOR MONEY DAMAGES AND OTHER RELIEF

Plaintiffs, Lorain County, Ohio ("County"), City of Elyria, Ohio ("Elyria"), and City of Lorain, Ohio ("Lorain"), for their Class Action Complaint for Money Damages and Other Relief against Defendants, Medical Mutual of Ohio ("MMO") and Medical Mutual Services, LLC ("MMS"), and each of them, jointly and severally (MMO and MMS are collectively referred to as "Medical Mutual"), hereby claim, allege, state, and aver as follows:

INTRODUCTION

1. This class-action lawsuit challenges Medical Mutual's illegal scheme to misappropriate funds from Plaintiffs and Class members and from their respective employees and dependents to pay for Medical Mutual's so-called value-based contracts. Value-based contracts are contracts between Medical Mutual and medical providers that employ new payment methodologies and involve paying bonus incentives to medical providers.

2. Governmental entities in Ohio, like Plaintiffs, including but not limited to counties, municipalities, cities, townships, villages, health-and-family service agencies, boards of developmental disabilities, state employees, and retirees, trusted Medical Mutual to administer their self-funded employee benefit plans for their employees in accordance with the terms and provisions of Medical Mutual's administrative-services-only contracts (ASOs).

3. According to their ASOs, Plaintiffs and class members directed large sums of money to Medical Mutual in its capacity as the third-party administrator for Plaintiffs' and Class members' self-funded health plans. Medical Mutual was then contractually required to pay the health-care claims of Plaintiffs' and Class members' employees.

4. But instead of solely paying Plaintiffs' and Class members' health-care claims with the funds its received from Plaintiffs and Class members, Medical Mutual surreptitiously charged and retained, and continues to charge and retain, fees that the ASOs do not authorize or permit —namely,

hidden and unexplained $2.13 and $4.26[1] charges that one of Medical Mutual's representatives admitted are "not included in [Plaintiffs' and Class members'] contract[s] specifically."

5. These extracontractual and fraudulent fees arise from Medical Mutual's value-based contracts[2] with the Cleveland Clinic and the Clinic's Quality Alliance network and possibly other medical providers throughout Ohio.

6. At all relevant times, Medical Mutual knew that its ASOs with Plaintiffs and Class members did not allow charges related to its value-based contracts.

7. Because Medical Mutual's ASOs do not allow these charges, Medical Mutual designed a scheme to hide and misrepresent value-based fees as ordinary claims for medical treatment by embedding these value-based fees into its Plaintiffs' and Class members' Standard Weekly Detail Reports.

8. Medical Mutual used this scheme as an artifice and camouflage to wrongfully and unlawfully obtain payments from Plaintiffs and Class members to pay its own obligations to various medical providers under its own value-based contracts with those medical providers.

9. Medical Mutual's misdirection created the illusion that Medical Mutual did not increase its fees or costs to Plaintiffs or Class members. But by wrongfully hiding and including value-based charges, Medical Mutual inflated the amounts it reported as hospital claims to Plaintiffs and Class members.

---

[1] Plaintiffs believe Medical Mutual's hidden and unexplained charges have changed from time to time, and Plaintiffs' Complaint implicates these charges at whatever price.

[2] Value-based contracts and systems employ payment methodologies that differ from volume-based systems. One of most significant differences is that value-based methodologies provide medical organizations with bonuses for the quality and cost of care delivered to the patient.

10. To further its scheme and to maintain the secrecy and concealment of its fraud, Medical Mutual refuses to produce the data related to health plans if requested, even though Medical Mutual's ASO contracts require it to provide this information upon request.

11. Along with refusing to produce health-plan data, Medical Mutual has failed to take any corrective actions and continues to conceal its value-based fees.

12. Plaintiffs bring this case to recoup the money that Medical Mutual stole from them and Class members when Medical Mutual breached the parties' ASOs and defrauded Plaintiffs by charging illegitimate and hidden charges related to Medical Mutual's value-based contracts with medical providers.

PARTIES, JURISDICTION, AND VENUE

13. The County is an Ohio political subdivision with its administrative headquarters at 226 Middle Avenue, Elyria, Lorain County, Ohio.

14. Elyria is an Ohio political subdivision and municipal corporation with its administrative headquarters at Elyria City Hall, 131 Court Street, Elyria, Lorain County, Ohio.

15. Lorain is an Ohio political subdivision and municipal corporation with its administrative headquarters at Lorain City Hall, 200 West Erie Avenue, Lorain, Ohio.

16. Section 9.833 of the Ohio Revised Code permits political subdivisions, like Plaintiffs and Class members, to provide health-care benefits for their officers, employees, and their eligible dependents under an individual self-insurance program.[3]

17. MMO is a not-for-profit mutual insurance company organized under Ohio law with its principal place of business at 2060 East Ninth Street, Cleveland, Ohio. MMO is also the parent

[3] R.C. 9.833 further permits a political subdivision that provides health-care benefits to join with other political subdivisions to procure health-care benefits for their respective officers, employees, and eligible dependents through a self-funded health plan.

company of three entities that share its address: MMS, Medical Health Insuring Corporation of Ohio, and Consumers Life Insurance Company. These entities offer multiple product lines.

18. MMS is a limited liability company organized and existing under Ohio law as a wholly owned subsidiary of MMO.

19. The Employees Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 et seq., and federal regulations promulgated thereunder, do not govern the ASOs between Plaintiffs and Medical Mutual or the ASOs between and Class members and Medical Mutual.

20. The Court has subject-matter jurisdiction over the common-law claims for breach of contract, common-law fraud and unjust enrichment, and over the statutory claim for violations of Ohio's Deceptive Trade Practices Act, R.C. 4165.01 et seq., against Medical Mutual.

21. Venue is proper under Rules 3(B)(3) and (6) of the Ohio Rules of Civil Procedure because Medical Mutual conducted activities that gave rise to the claims for relief in Lorain County and because all or part of the claims for relief arose in Lorain County.

FACTUAL ALLEGATIONS

A. How self-funded health plans work.

22. Millions of Americans, including most Ohioans, obtain health-insurance coverage on their own, through their employer, or through a family member's employer. Employers provide health insurance on either a fully insured or a self-funded basis.

23. Plaintiffs and Class members offer their employees the eligibility to participate in their self-funded health plans.

24. Government entities, like Plaintiffs and Class members, often self-fund their health plans for their employees. When an employer self-funds a health plan, the employer sponsors the benefits plans and, by doing so, assumes the risk for payment of the medical claims under it.

25. Self-funding a health plan means the employer contributes premiums, which may be paid, at least in part, by the employee, to a plan trust, or the employer maintains the contributed premiums in its general assets to pay for future claims. The employer uses these premiums to pay the enrolled employees' and their dependents' health-care claims.

26. A written official plan document or instrument sets forth the self-funded health plan's specific details, including the procedure for establishing the plan's funding, the identities of the people who have authority to amend the plan, the procedure for amending the plan, and the bases by which the parties make payments to and from the plan.

27. An employer that provides a self-funded health plan often enters an administrative-services-only agreement, known in the marketplace as an ASO (or sometimes an ASA), with a third-party commercial-insurance company, like Medical Mutual, to act as the employer's third-party administrator to oversee processing claims and other administrative services.

B. Plaintiffs contracted with Medical Mutual to administer their self-funded health plans for their employees and families.

28. Medical Mutual claims that it "is the oldest and largest health insurance company headquartered in the State of Ohio"[4] and is "one of the country's oldest and most trusted insurance companies."[5]

[4] Medical Mutual, homepage, https://www.medmutual.com (last visited Feb. 3, 2017); Medical Mutual, Corporate Profile, https://www.medmutual.com/About-Medical-Mutual/Corporate-Profile.aspx (last visited Feb. 3, 2017).

[5] *Id.* at Individuals & Families/Medical Mutual Advantage/Why Choose Medical Mutual?, https://www.medmutual.com/For-Individuals-and-Families/Why-Choose-Medical-Mutual/Medical-Mutual-Advantage.aspx (last visited Feb. 3, 2017).

29. Medical Mutual's statement of "Service Philosophy and Values" asserts that Medical Mutual "create[s] peace of mind. *Our customers can trust us* to do things right and to help them get value from their health plan."[6]

30. Medical Mutual's "Service Philosophy and Values" further explains that "[w]ith $2 billion in annual revenue you can be assured that we have the stability to continue our tradition of providing the highest quality health insurance for individuals and families[,]" and that Medical Mutual's "*products are priced to simply cover claims and administrative expenses*."[7]

31. Medical Mutual sells health-insurance products, including individual and group-health plans, and related services, such as third-party administrative services, to more than 1.6 million individual customers and over 25,000 group customers.[8] Medical Mutual's clients include more than 650 counties, cities, townships, villages, health-and-family service agencies, boards of developmental disabilities, state employees, and retirees.[9]

32. Medical Mutual provides third-party administrative services for governmental entities with self-funded plans, like Plaintiffs and Class members.

33. The parties to these ASOs with Medical Mutual are the employer (like Plaintiffs and Class members) and Medical Mutual. The ASOs identify the employer as the "Group."

34. Plaintiffs and Class members are parties to ASOs with Medical Mutual that require Medical Mutual to provide certain administrative services to their health plans.

---

[6] *Id.*

[7] Medical Mutual, Individuals & Families/Medical Mutual Advantage/Why Choose Medical Mutual?, https://www.medmutual.com/For-Individuals-and-Families/Why-Choose-Medical-Mutual/Medical-Mutual-Advantage.aspx (emphasis added) (last visited Feb. 3, 2017).

[8] *Id.*

[9] *Id.* at Employers/Common Issues Faced by Government and Education Sectors/Plans & Products, https://www.medmutual.com/For-Employers/Plans-Products/Common-Issues-Faced-By-Government-and-Education-Sectors.aspx (last visited Feb. 3, 2017).

35. Medical Mutual's ASO and its renewals are standard boilerplate documents that Medical Mutual prepares and presents to Groups, including to Plaintiffs and Class members. These materials set forth the rights and obligations of Medical Mutual and each Group, including Plaintiffs and class members, concerning Medical Mutual's Group self-funded health-plan administration.

36. Plaintiffs and Medical Mutual, and Class members and Medical Mutual, signed boilerplate ASOs for Medical Mutual to provide administrative services for Plaintiffs' and Class members' health plans.

37. The County signed an ASO with Medical Mutual that the parties have renewed.[10]

38. Elyria signed an ASO with Medical Mutual that the parties have renewed.[11]

39. Lorain signed an ASO with Medical Mutual that the parties have renewed.[12]

40. Plaintiffs paid Medical Mutual the fees required by their ASOs and by any amendments or renewal addenda.

41. Plaintiffs' and Class members' ASOs include the following key sections:

a. Medical Mutual agrees to administer Plaintiffs' health plans, while (i) providing Plaintiffs access to Medical Mutual's network of providers and (ii) receiving, processing, and paying all covered medical benefits claims with money that Plaintiffs pay to Medical Mutual;

b. Medical Mutual is to process and pay only those medical claims and services that meet the ASO's definition of a "Covered Service," which is defined as any "service, supply or accommodation described in the Benefit Books, schedules of benefits, riders, addenda or Amendments";

c. Only the Group (meaning Plaintiffs and Class members)—not Medical Mutual—determines what services are covered;

d. Medical Mutual does not have the authority to change what is a "Covered Service";

---

[10] Agreements in the County's possession are attached collectively as Exhibit 1. Plaintiffs are in the process of locating Plaintiffs' additional agreements. Medical Mutual possesses any agreements not presently attached to this Complaint.

[11] Agreements in Elyria's possession are attached collectively as Exhibit 2.

[12] Agreements in Lorain's possession are attached collectively as Exhibit 3.

e. Medical Mutual pays medical providers for Covered Services, then sends the Groups weekly invoices for those medical claims. Based on Medical Mutual's weekly invoices, the Groups reimburse Medical Mutual for having paid the medical claims reflected in Medical Mutual's invoices;

f. Medical Mutual is to "use reasonable care and due diligence" when performing its duties;

g. Medical Mutual must maintain its records, including those relating to claims processing for seven years, and Plaintiffs have the right to audit those records;

h. Medical Mutual will send "Weekly Invoices . . . each week for claims paid by Medical Mutual Services during the preceding week," and Plaintiffs "will pay the invoices amount" within two business days";

i. Along with invoices for its administrative fees, Medical Mutual is to "issue a separate invoice on a monthly basis for the month's claims less amounts paid for weekly invoices for the month." Payments for those are due on the later of the first of the month or within ten days;

j. If Medical Mutual does not receive payment for any invoice, it "will suspend processing of the group's claims and will not release future claim payments until payment is received from the Group." For any failure to pay, Medical Mutual gives itself the right to change its invoicing method immediately; and

k. The ASO constitutes the parties' "entire understanding" regarding their relationship and obligations, and only a mutual written agreement executed by both parties under the ASO's amendment provision can change the ASOs' terms and provisions.

42. Plaintiffs' and Class members' ASOs do not permit Medical Mutual to bill for any charges related to Medical Mutual's value-based contracts.

43. Medical Mutual's ASOs are exempt from ERISA.

C. Medical Mutual entered value-based contracts with medical providers, including the Cleveland Clinic's Quality Alliance network, to pay medical providers amounts of money above the amounts allowed by the parties' ASOs.

44. The Cleveland Clinic Foundation's Community Physician Partnership ("CCF Physician Partnership") is a network of physicians, hospitals, health centers, and other providers

affiliated with the Cleveland Clinic Health System. On behalf of its members, the CCF Physician Partnership negotiates with payers and facilitates contracts for independent physician members.[13]

45. In 2010, Medical Mutual and the Cleveland Clinic Physician Partnership entered an agreement to form a relationship that led to the creation of the Quality Alliance.[14]

46. The Cleveland Clinic promoted its agreement with Medical Mutual as "the first of its kind in Ohio."[15] The Clinic boasted that the agreement would allow the CCF Physician Partnership to "obtain additional resources to increase quality outcomes and that [p]articipating physicians [would] see additional incentives for improving access and quality . . . ."[16]

47. This value-based agreement between Medical Mutual and the CCF Physician Partnership began in or about January 2011.[17]

48. According to the Quality Alliance's website, value-based systems differ from traditional volume-based systems. A value-based system is a "pay-for-performance" model where medical providers "receive incentives for reaching quality targets."[18]

---

[13] Center for Studying Health System Change, *Hospitals Woo Independent Physicians* (September 2010), http://www.hschange.org/CONTENT/1154/ (last visited Feb. 3, 2017).

[14] PR Newswire, *Cleveland Clinic Community Physician Partnership, Medical Mutual Explore Innovative Relationship to Enhance Coordination and Quality of Care* (November 11, 2010), http://tinyurl.com/z88bhst (last visited Feb. 3, 2017).

[15] *Id.*

[16] *Id.*

[17] *Id.* The Quality Alliance "officially launched in the market place" around July 2010. Cleveland Clinic Community Physician Partnership, Special Edition Newsletter, *Medical Mutual of Ohio – An Innovative new Agreement* (July 2011).

[18] Cleveland Clinic Quality Alliance, Home/Services/Value-Based Contracting, https://www.ccqualityalliance .org/Services/Value-Based-Contracting.aspx (last visited Feb. 3, 2017).

49. The Cleveland Clinic and its CCF Physician Partnership identify their value-based network as the "Cleveland Clinic Quality Alliance" or the "Quality Alliance."[19]

50. The Quality Alliance is "an integrated provider network comprised of independent physician practices and employed Cleveland Clinic physicians . . . ."[20]

51. Within two years of the agreement with Medical Mutual, the Quality Alliance had become "the third-largest clinically integrated network in the United States."[21]

52. By 2015, with the Cleveland Clinic "committed to value-based care," the Clinic "ha[d] grown the Cleveland Clinic Quality Alliance into the nation's second-largest and northeast Ohio's largest clinically integrated network [with] more than 5,900 physician members, both employees and independent physicians from the community."[22]

53. Presently, the Quality Alliance "span[s] more than 12 counties in Northeast Ohio and three counties in Buffalo, New York, area."[23] The Quality Alliance includes 27 institutes, 10 hospitals

---

[19] *Id.* at Home/About/FAQs, "What is the Quality Alliance," https://www.ccqualityalliance.org/About/FAQs.aspx (last visited Feb. 3, 2017); *see also* Cleveland Clinic, *Moving Towards Higher-Quality, Cost-Efficient Healthcare*, eRounds (Spring 2013), http://my.clevelandclinic.org/professionals/publications/erounds-spring-2013 (last visited Feb. 3, 2017); Cleveland Clinic, 2015 Outcomes, http://tinyurl.com/hvup637 (last visited Feb. 3, 2017).

[20] Cleveland Clinic Quality Alliance, Home/About/Us, https://www.ccqualityalliance.org/About/About-Us.aspx (last visited Feb. 3, 2017). As of 2011, the Quality Alliance included "employed [2,299] Cleveland Clinic physicians, [346] private practice physicians and [200] hospital-based emergency medicine physicians" practicing in Cuyahoga, Geauga, Lake, Lorain, Medina, Portage, and Summit Counties. CCF Physician Partnership, Special Edition Newsletter, *Medical Mutual of Ohio – An Innovative new Agreement* (July 2011).

[21] Cleveland Clinic, eRounds (Spring 2013), http://my.clevelandclinic.org/professionals/publications/erounds-spring-2013; Crain's Cleveland Business, Cleveland Clinic's Quality Alliance is growing stronger (April 29, 2013), http://www.crainscleveland.com/article/20130429/SUB1/130429850/cleveland-clinics-quality-alliance-is-growing-stronger (the Quality Alliance "began with 50 physician members and since has ballooned to include more than 5,100 members—a collective that now includes the Clinic's own docs.") (last visited Feb. 3, 2017).

[22] Cleveland Clinic, 2015 Outcomes, http://tinyurl.com/hvup637.

[23] Cleveland Clinic Quality Alliance, Home/About/Us, https://www.ccqualityalliance.org/About/About-Us.aspx.

(9 regional hospitals, including 18 full-service family health centers with more than 150 northern Ohio outpatient locations) . . . and more than 150 affiliated providers."[24]

54. The Quality Alliance's express purpose is to "negotiate[s] value-based contracts that reward [its] physicians for improving quality and lowering costs."[25] With the Quality Alliance, "physicians now have the opportunity to negotiate for value-based payments that reward quality and cost improvements."[26]

55. The Quality Alliance's value-based contracts allows "[p]roviders [to] receive incentives for reaching quality targets."[27]

56. The Quality Alliance's website illustrates that its "payment model options" include a "pay-for-performance" model.[28]

57. Because of the Quality Alliance and its value-based contracts, medical providers who belong to the Quality Alliance are able "to succeed in pay-for-performance, quality-based incentive programs and value-based pricing."[29]

---

[24] *Id.* at Home, https://www.ccqualityalliance.org/Home.aspx (last visited Feb. 3, 2017).

[25] *Id.* at Home/About/About Us, "What we do", https://www.ccqualityalliance.org/About/About-Us.aspx (last visited Feb. 3, 2017).

[26] Cleveland Clinic Quality Alliance, Home, https://www.ccqualityalliance.org/Home.aspx (last visited Feb. 3, 2017).

[27] *Id.* at Home/Services/Value-Based Contracting, https://www.ccqualityalliance.org/Services/Value-Based-Contracting.aspx (emphasis added) (last visited Feb. 3, 2017).

[28] *Id.* ("This model rewards providers for adhering to pre-defined, evidence-based medical practices, levels of productivity and administrative efficiency, use of information technology, reporting of performance indicators and participation in performance-enhancing activities.").

[29] *Id.* at Home/About/FAQs, "What is the value proposition for the physicians?", https://www.ccqualityalliance.org/About/FAQs.aspx (last visited Feb. 3, 2017).

D. One class member discovered Medical Mutual's secret scheme to assess value-based charges only when it realized that Medical Mutual had charged claims for employees who no longer worked it.

58. At the end of 2015, one class member (the "Municipality") first became aware of countless $4.26 and $2.13 charges because Medical Mutual had charged $2.13 for medical claims of employees who no longer worked for the Municipality.

59. After the Municipality's investigation, it discovered that Medical Mutual was submitting to it value-based payments based on Medical Mutual's relationship with the CCF Physician Partnership and the Quality Alliance network.

60. On November 10, 2015, when the Municipality questioned Medical Mutual about these value-based charges, Medical Mutual's representative identified the charges as value-based costs associated with Medical Mutual's agreement with the CCF Physician Partnership:

> The charges for $2.13 for both [employee names omitted] are what are called Value-based payments. This is an agreement MMO made with Cleveland Clinic's Community Physician Partnership to reimburse doctors for improving administrative and clinical processes. The idea is to reimburse doctors for better patient outcomes.

61. The representative reported that the charges were for "anyone who had services rendered at Cleveland Clinic and billed by Community Physician Partnership."

62. Days later, when the Municipality questioned the Medical Mutual representative about whether its ASO allowed these value-based charges, the representative admitted these charges' impropriety:

> It's a contractual agreement between Medical Mutual and value-based providers in which Cleveland Clinic is one. It's an incentive based program for managing patients care, *it is not included in your contract specifically*. It functions like a claim payment.[30]

[30] Emphasis added.

63. In January, 2016, when the Municipality continued to question Medical Mutual about these suspicious charges, Medical Mutual wrongly claimed that the ASO's Cost Management Programs provision and pricing addenda permitted increases for value-based payments to medical providers.

64. But the Cost Management Programs provision and pricing addenda do not permit increases for value-based payments to medical providers:

> The Group agrees to cooperate with Medical Mutual Services and Providers in cost management utilization programs which Medical Mutual Services implements from time to time, such as preadmission certification, concurrent review, case management and other carrier liability programs to the extent that these programs do not conflict with the Plan documents.
>
> The Group shall inform eligible Participants of the requirements of Medical Mutual Services' applicable network programs and assist Medical Mutual Services 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 maintain and set forth in its Benefit Books an incentive plan reasonably calculated to encourage eligible participants and the Eligible Dependents to utilize network providers.

65. Nothing in the ASO—neither the Cost Management Programs provision, the pricing addenda, nor anything else—permits Medical Mutual to charge value-based payments to the Plaintiffs or Class members.

66. The ASO neither mentions Medical Mutual's value-based programs nor allows Medical Mutual to charge the Plaintiffs or Class members for Medical Mutual's agreement to pay the Cleveland Clinic under value-based programs.

67. As part of Medical Mutual's effort to cheat Plaintiffs and Class members into paying improper charges as claims, Medical Mutual requested payment from Plaintiffs and Class members for value-based charges separate from, and at a much later time than, the claims for which Medical Mutual alleged that these value-based payments arose.

68. Sometimes, Medical Mutual even charged Plaintiffs and Class members in the next calendar year, as the foregoing Medical Mutual representative described:

> Rather than tying it to the claim as it is processed we pay it afterwards when the amounts are earned so it comes through separately as its own claim . . . . The incentive charges you see on your invoices are for prior dates of service as we do not issue the incentives during the year they were incurred.

69. Upon learning of these improper charges, the Municipality directed Medical Mutual to provide its claims data and to stop assessing them.

70. Although Medical Mutual's ASOs with the Plaintiffs and class members require Medical Mutual to retain for at least seven years records relating to its responsibilities under ASOs and to provide Plaintiffs and Class members, including the Municipality, access to their data and claims records and to their payments related to their ASO, Medical Mutual has refused to provide this information.

71. The $2.13, $4.26, and likely other charges, as invoiced to and unknowingly paid by the Plaintiffs and Class members, were not Covered Services under the terms of their ASOs.

72. Medical Mutual wrongfully, improperly, and illegally charged these value-based payments to the Plaintiffs and Class members.

73. Medical Mutual had no authority, permission, or right, contractual or otherwise, to charge the Plaintiffs and Class members for charges related to Medical Mutual's value-based contracts.

74. Plaintiffs and Class members did not agree in writing to amend their ASOs to allow Medical Mutual to charge them for costs associated with Medical Mutual's value-based contracts.

E. Medical Mutual's scheme secretly charges Plaintiffs and class members the costs that Medical Mutual owes medical providers under Medical Mutual's value-based contracts with these medical providers.

75. Beginning sometime after Medical Mutual entered its value-based agreement with the Cleveland Clinic Quality Alliance, Medical Mutual began charging Plaintiffs and Class members the costs related to Medical Mutual's value-based contracts.

76. Medical Mutual's value-based charges tend to be for $4.26 and $2.13 each.[31]

77. Medical Mutual charged Plaintiffs and Class members these $4.26 and $2.13 amounts (and perhaps other value-based contract costs) without Plaintiffs' knowledge or consent, as these charges were not part of Plaintiffs' ASOs with Medical Mutual.

78. Since the charges associated with Medical Mutual's value-based contracts with the Quality Alliance and other medical providers are not a service, claim, fee, or any other charge authorized by Plaintiffs' ASOs, these charges were not permitted and Medical Mutual should not have charged them to Plaintiffs.

79. To induce Plaintiffs' payment under their ASOs, Medical Mutual hid these charges as claims.

80. Because Medical Mutual knows these value-based contract charges are not a Covered Service under Plaintiffs' and Class members' ASOs, Medical Mutual concealed these charges by classifying them as claim expenses covered under Plaintiffs' and Class members' ASOs. Thus, Medical Mutual made its value-based charges appear like every other claim on its invoices.

81. But Plaintiffs and Class members neither agreed nor consented to pay these charges as claims under their ASOs.

[31] These charges used to be less, until Medical Mutual raised the price to Plaintiffs and Class members. Other hidden and illegal charges might also exist.

82. Plaintiffs and Class members also never authorized Medical Mutual to process these charges—whether as claims expenses, access fees, administrative fees, or charges related to value-based contracts—and Medical Mutual was never entitled to receive reimbursement for these charges from Plaintiffs or Class members.

83. Medical Mutual did not have the authority, permission, or right to unilaterally expand the definition of Covered Services under Plaintiffs' and Class members' ASOs.

84. Plaintiffs and Class members never agreed in writing to amend their ASOs to include charges that Medical Mutual owes to the Cleveland Clinic or to any other medical provider under value-based agreements.

85. Unsuspecting Plaintiffs' and Class members' payments to Medical Mutual for these improper, wrongful and unauthorized value-based charges may have also derived from Medical Mutual's value-based contracts with medical providers other than the Quality Alliance.

F. Medical Mutual's fraudulent concealment of its value-based charges tolls the running of any applicable statutes of limitations.

86. To the extent Medical Mutual's misconduct arguably prevented Plaintiffs and Class members from bringing their claims before any applicable limitations period expired, Medical Mutual's fraudulent concealment of its wrongdoing tolls any statutes of limitations.

87. Medical Mutual took affirmative steps to conceal Plaintiffs' legal claims such that Plaintiffs, despite their continued exercise of due diligence, could not have discovered the existence of their legal claims until recently.

88. Medical Mutual wrongfully concealed from Plaintiffs and Class members its wrongful conduct that, as a party to Plaintiffs' and Class members' ASOs, Medical Mutual had duty to disclose.

89. Medical Mutual hid its illegal value-based charges from Plaintiffs and Class members by taking the following affirmative steps to design, style, and present its Standard Weekly Detail

Reports in a manner that concealed—rather than revealed—Medical Mutual's wrongful, unauthorized, and fraudulent charges:

a. Medical Mutual buried its $4.26 and $2.13 charges in random places among thousands of legitimate charges;

b. Medical Mutual assigned claim numbers to wrongful charges just like it assigned claim numbers to legitimate charges;

c. Medical Mutual assigned wrongful claims and charges to various people (employed, formerly employed, or sometimes even deceased) when these people had received no current (or perhaps any) services associated with these claims and charges;

d. Claim numbers for Medical Mutual's fraudulent charges followed sequentially legitimate claim numbers, even though the fraudulent claims related to medical visits that occurred over a year earlier, if ever; this sequencing created the appearance that Medical Mutual's fraudulent charges were for current claims when they were not;

e. Medical Mutual, although billing legitimate claims within one or two months of the dates of service, waited over a year to present its wrongful claims and charges, which made it difficult or impossible to match these illegitimate claims and charges to legitimate dates of service;

f. Medical Mutual labelled legitimate and illegitimate claims identically as "ORIG" claims, thus intending for Plaintiffs and Class members to believe that old, illegitimate claims were new, legitimate claims subject to immediate payment;

g. Regardless of the reason for the request, Medical Mutual refuses to provide Plaintiffs or Class members any information related to their ASOs and claims payments;

h. The fact that Medical Mutual buried its wrongful and illegitimate charges in its Standard Weekly Detail Reports does not mean that Medical Mutual disclosed these charges; rather, Medical Mutual's Standard Weekly Detail Reports had to include these charges for Medical Mutual to receive payment for them; and

i. Medical Mutual placed these charges in Standard Weekly Detail Reports in a hidden, deceptive, and buried manner so that Plaintiffs and Class members could not know, realize, or reasonably discover that Medical Mutual had cheated them.

90. Medical Mutual's affirmative methods of concealment demonstrate its intention to prevent Plaintiffs and Class members from detecting its illegal conduct. Medical Mutual did not sufficiently apprise Plaintiffs and Class members of its deceptive scheme because Medical Mutual's intention was to hide its fraud from Plaintiffs and Class members.

91. Plaintiffs and Class members exercised due diligence in reviewing, processing, and paying their respective Medical Mutual invoices, as follows:

a. Plaintiffs and Class members employ personnel devoted to receiving, reviewing, processing, and paying the charges described in Medical Mutual's Standard Weekly Detail Reports;

b. Despite routinely receiving, reviewing, processing, and paying Medical Mutual's bills, none of Plaintiffs' or Class members' personnel detected, much less knew how to detect, Medical Mutual's wrongdoing because Medical Mutual had so cleverly disguised it, as was necessary for Medical Mutual's scheme to succeed;

c. The Municipality discovered Medical Mutual's scheme only when it hired a private health-care consultant to help it understand and lower its health-care costs—a matter unrelated to the Municipality having suspected any wrongdoing by Medical Mutual;

d. When the Municipality pressed Medical Mutual for its claims data, Medical Mutual refused—and continues to refuse—to provide it, despite the ASO's requirement for Medical Mutual to do so;

e. Only when the Municipality exported its Standard Weekly Detail Reports to an Excel spreadsheet format and reordered Medical Mutual's charges by amount did streams of unauthorized and improper charges unrelated to current and legitimate claims emerge. The Municipality had no reason to conduct this conversion in the normal course of its claims-paying business but did so only as part of its independent health-care-cost audit; and

f. Nothing associated with Plaintiffs' and Class members' routine receipt, review, processing, and payment procedures gave them any basis, suspicion, or hint that Medical Mutual was cheating them; indeed, Medical Mutual designed its scheme to convey honesty.

92. The manner, fashion, and form in which Medical Mutual presented and presents its Standard Weekly Detail Reports to Plaintiffs and Class members demonstrates that Medical Mutual

concealed all indicia of its fraud and never intended to inform Plaintiffs or Class members of their illegal charges. Nothing Medical Mutual has provided to Plaintiffs or Class members was intended to inform them of Medical Mutual's wrongful charges.

93. Having only recently discovered Medical Mutual's fraudulent and wrongful conduct, Plaintiffs and Class members are now bringing their claims in this action.

94. Medical Mutual's fraudulent concealment tolls the running of any applicable limitations periods.

CLASS-ACTION ALLEGATIONS

95. Plaintiffs bring this lawsuit under Rules 23(B)(2) and 23(B)(3) of the Ohio Rules of Civil Procedure on behalf of the following Class:

> All governmental entities (including, but not limited to, counties, cities, townships, villages, health-and-family-service agencies, boards of development disabilities, and state employees and retirees) in Ohio with self-funded health plans administered by Medical Mutual that paid charges related to Medical Mutual's value-based contracts when their health plans did not contain language referring to value-based payments.
>
> Excluded from the Class are (1) Medical Mutual and any entity in which Medical Mutual has a controlling interest; (2) Class counsel, employees of Class counsels' firms, and Class counsels' immediate family members; (3) defense counsel, their employees, and their immediate family members; and (4) any judicial officer who considers or renders a decision or ruling in this case, their staff, and their immediate family members.

96. Plaintiffs paid the charges associated with Medical Mutual's value-based contracts that were not referred to in their ASOs; therefore, Plaintiffs are class members.

97. Class members are identifiable from Medical Mutual's computerized records that reflect the self-funded Ohio governmental entities from which Medical Mutual charged and collected value-based payments.

98. Class members are so numerous that joinder is impracticable. While the precise number of Class members is known only to Medical Mutual, Medical Mutual reports that it has over 25,000 group customers, including more than 650 counties, cities, townships, villages, health-and-family-service agencies, boards of developmental disabilities, state employees, and retirees.[32]

99. Common legal and factual questions exist among all Class members, including, but not limited to:

a. Whether Medical Mutual breached its ASOs with Class members;

b. Whether Medical Mutual was permitted to charge Class members for charges associated with Medical Mutual's value-based contracts;

c. Whether Medical Mutual's uniform representations, omissions, and conduct regarding these charges were misleading or false;

d. Whether Medical Mutual's uniform representations, omissions, and conduct deceived Class members into believing their ASOs permitted these charges;

e. Whether Medical Mutual hid these charges from Class members;

f. Whether Medical Mutual defrauded Class members by failing to disclose these charges;

g. Whether Medical Mutual defrauded Class members by concealing these charges;

h. Whether Class members unjustly enriched Medical Mutual;

i. Whether Medical Mutual's uniform behavior toward Class members constituted affirmative misrepresentations, intentional omissions, or unconscionable commercial practices that violated the Ohio Deceptive Trade Practices Act;

[32] Medical Mutual, Employers/Common Issues Faced by Government and Education Sectors/Plans & Products, https://www.medmutual.com/For-Employers/Plans-Products/Common-Issues-Faced-By-Government-and-Education-Sectors.aspx (last visited Feb. 3, 2017).

j. Whether Medical Mutual owes Plaintiffs and Class members damages and the amount of these damages;

k. Whether injunctive relief for the benefit of Plaintiffs and Class members is appropriate; and

l. Whether a declaration of Medical Mutual's wrongdoing is appropriate.

100. Plaintiffs' claims are typical of Class members' claims, and Plaintiffs will fairly and adequately represent Class members' interests.

101. Plaintiffs' attorneys are experienced and competent in complex class-action litigation and will competently and adequately represent Class members' interests.

102. Medical Mutual has acted or refused to act on grounds generally applicable to the Class, thereby making final injunctive relief or corresponding declaratory relief with respect to the Class appropriate.

103. Questions of law or fact common to Class members predominate over any questions affecting only individual Class members.

104. Class certification is superior to any other method or procedure for fairly and efficiently adjudicating Class members' claims because:

a. Economies for the Court and the parties exist from litigating the common issues on a classwide basis instead of on a repetitive, individual basis;

b. Each Class member's damage claim is too small to make individual litigation an economically viable possibility, for which reason few Class members would have any interest in individually prosecuting separate actions;

c. Despite the relatively small size of each Class member's claim, the aggregate volume of their claims—coupled with the economies of scale inherent in litigating similar claims on a common basis—will enable Class counsel to litigate this case on a cost-effective basis; and

d. Class treatment is required for optimal deterrence and for limiting the reasonable legal expenses incurred by Class members.

105. Plaintiffs anticipate no unusual difficulties in managing and maintaining this case as a class action.

106. Class certification is also appropriate under Civ. R. 23(B)(2) because Medical Mutual has acted on grounds generally applicable to Plaintiffs and Class members, all of whom are at imminent risk of irreparable harm from Medical Mutual's charging and continuing to charge hidden amounts related to its value-based agreements. Thus, Plaintiffs and Class members are entitled to a declaration that establishes their rights and Medical Mutual's duties with respect to Medical Mutual's charges.

COUNT I
(Breach of Contract)

107. Plaintiffs reallege and incorporate by reference every allegation set forth in paragraphs 1 through 106 as if they rewrote these paragraphs here.

108. Plaintiffs and Class members contracted with Medical Mutual to enter ASOs.

109. Medical Mutual's ASOs and other documentation with Plaintiffs are standardized, and Medical Mutual uses similar standardized contracts and documentation with all Class members.

110. Plaintiffs and Class members fully performed and satisfied all their respective obligations under their ASOs.

111. The ASOs required Medical Mutual to process and make payments on behalf of Plaintiffs and Class members only for medical claims and services that satisfied the definition of Covered Services, as defined in the ASOs. In exchange for Medical Mutual making these payments, Plaintiffs and Class members agreed to pay Medical Mutual certain fees.

112. Medical Mutual's ASOs never explained or disclosed that Medical Mutual would charge Plaintiffs and Class members payments related to Medical Mutual's value-based contracts.

113. Because Medical Mutual (a) charged Plaintiffs and Class members for items related to Medical Mutual's value-based contracts, even though their ASOs did not permit this; (b) did not report or disclose these value-based charges; and (c) submitted false and misleading statements to Plaintiffs and Class members, Medical Mutual breached its ASOs with Plaintiffs and Class members.

114. As a direct and proximate result of Medical Mutual's breaches of its ASOs with Plaintiffs and Class members, Plaintiffs and Class members have suffered and continue to suffer damages from the overpayment of their premiums and fees under the ASOs in an amount exceeding $25,000, to be determined at trial.

COUNT II
(Common-Law Fraud)

115. Plaintiffs reallege and incorporate by reference every allegation set forth in paragraphs 1 through 114 as if they rewrote these paragraphs here.

116. Medical Mutual made material and false representations to Plaintiffs and Class members about the charges it submitted to them for payment. Medical Mutual represented to Plaintiffs and Class members that these charges were Covered Services under Plaintiffs' and Class members' ASOs and that it was using funds received from Plaintiffs and Class members to pay for Covered Services.

117. Medical Mutual's unilateral decision to impose upon Plaintiffs and Class members costs related to Medical Mutual's value-based contracts and to conceal these costs by classifying them as Covered Services was intended to, and did, mislead and deceive Plaintiffs and Class members.

118. Since these value-based charges were not Covered Services under Plaintiffs' and Class members' ASOs, Medical Mutual had (and has) a duty to disclose these charges to Plaintiffs and Class members and to obtain their written consents to these charges.

119. Medical Mutual has concealed from and affirmatively misrepresented to Plaintiffs and Class members the costs related to Medical Mutual's value-based contracts when Medical Mutual had (and has) a duty to disclose the truth to Plaintiffs and Class members.

120. Disclosure of these costs' true nature was material to the transaction at hand—namely, proper implementation of Plaintiffs' and Class members' ASOs.

121. Medical Mutual actively and intentionally concealed the truth. It made affirmative misrepresentations—with knowledge of these misrepresentations' falsity or with such utter disregard and recklessness as to whether its concealment and affirmative misrepresentations were true or false—that this Court may infer Medical Mutual's knowledge of its wrongdoing and the false and fraudulent nature of its representations and concealments.

122. Medical Mutual conducted its concealment and made its affirmative misrepresentations with the intent of misleading Plaintiffs and Class members into relying upon them, and Plaintiffs' and Class members' reasonable and justifiable reliance on them proximately caused their injuries.

123. Because Medical Mutual fraudulently concealed the fees related to its value-based contracts and falsely classified these fees as Covered Services, Plaintiffs' and Class members' respective reliance on Medical Mutual's invoices was reasonable and justifiable.

124. Medical Mutual's omission of any mention in its standardized, written communications sent to Plaintiffs and Class members that it was passing on to them the costs of its value-based contracts, while at the same time hiding and disguising these costs as though they were for Covered Services, constituted Medical Mutual's classwide mechanism for perpetrating its fraud.

125. Medical Mutual's omission from its standardized, written communications sent to Plaintiffs and Class members dispenses with Plaintiffs' and Class members' requirement of alleging and individually proving their reliance on Medical Mutual's false and reckless omissions.

126. Medical Mutual's gross and egregious fraud was aggravated by the existence of malice or ill will and was animated by actual malice or with reckless and callous disregard for the rights of Plaintiffs and Class members.

127. As a direct and proximate result of Medical Mutual's false and fraudulent misrepresentations and concealment, Plaintiffs and Class members have suffered and continue to suffer damages in an amount exceeding $25,000, to be determined at trial.

128. As a direct and proximate result of Medical Mutual's actions, under circumstances where it achieved its false and fraudulent scheme and made its false and fraudulent concealments with actual malice or with reckless and callous disregard for Plaintiffs' and Class members' rights, Plaintiffs and Class members are entitled to punitive damages in an amount in $25,000, to be determined at trial.

COUNT III
(Unjust Enrichment)

129. Plaintiffs reallege and incorporate by reference every allegation set forth in paragraphs 1 through 128 as if they rewrote these paragraphs here.

130. Plaintiffs and Class members conferred a benefit to Medical Mutual by paying Medical Mutual improper charges related to Medical Mutual's value-based contracts.

131. The benefits that Plaintiffs and Class members conferred on Medical Mutual were the product of Medical Mutual's fraud, misrepresentation, and bad faith.

132. Medical Mutual knew or reasonably should have known that Plaintiffs and Class members had conferred these benefits on it.

133. Medical Mutual retained the benefits that Plaintiffs and Class members conferred under circumstances where it would be unjust for Medical Mutual to do so without payment to Plaintiffs and Class members.

134. Plaintiffs and Class members lack an adequate legal remedy for recovering the benefits that they wrongly and unjustly conferred on Medical Mutual.

COUNT IV
(Violation of Ohio's Deceptive Trade Practices Act, R.C. §§ 4165.01 et seq.)

135. Plaintiffs reallege and incorporate by reference every allegation set forth in paragraphs 1 through 134 as if they rewrote these paragraphs here.

136. Medical Mutual has made and continues to make materially false, deceptive, and misleading statements of fact concerning its own product—namely, that the charges related to its value-based contracts are proper and payable costs under Plaintiffs' and Class members' ASOs.

137. In violation of R.C. 4165.02(A)(7), Medical Mutual unfairly and deceptively represented to Plaintiffs and Class members that the services it provided or purported to provide to them under their ASOs had sponsorship, approval, characteristics, uses, benefits, or qualities that they did not and do not have.

138. In violation of R.C. 4165.02(A)(9), Medical Mutual unfairly and deceptively represented to Plaintiffs and Class members that the services it provided or purported to provide to them under their ASOs were of a particular standard or quality (i.e., that the value-based claims were Covered Services) when those services were not of the represented standard or quality.

139. Medical Mutual intended for its materially false, deceptive, and misleading representations sent to Plaintiffs and Class members in standardized, written communications to deceive or to tend to deceive Plaintiffs and Class members.

140. Medical Mutual's materially false, deceptive, and misleading representations and concealments sent to Plaintiffs and Class members in standardized, written communications were material because these communications influenced Plaintiffs' and Class members' decisions to purchase ASOs from Medical Mutual.

141. The standardized, written nature of Medical Mutual's communications constituted the classwide mechanism for perpetrating Medical Mutual's DTPA violation. Medical Mutual's omission from its standardized, written communications sent to Plaintiffs and Class members dispenses with Plaintiffs' requirement of alleging and individually proving that each Class member considered these deceptive communications to have been material.

142. Medical Mutual introduced its deceptive, false, and misleading standardized, written communications into interstate commerce.

143. Medical Mutual's DTPA violation was and continues to be intentional, willful, wanton, malicious, and egregious conduct.

144. As a direct and proximate result of Medical Mutual's DTPA violations, Plaintiffs and Class members have suffered and continue to suffer damages in an amount $25,000.00, to be determined at trial.

COUNT V
(Injunctive Relief)

145. Plaintiffs reallege and incorporate by reference every allegation set forth in paragraphs 1 through 144 as if they rewrote these paragraphs here.

146. Plaintiffs and Class members are substantially likely to prevail on the merits because Medical Mutual committed a wrongful and fraudulent act when it charged and collected improper charges related to its value-based contracts.

147. Plaintiffs and Class members will suffer irreparable injury if this Court does not enjoin Medical Mutual's continuing misconduct.

148. If this Court does not enjoin Medical Mutual's continuing misconduct, the harm to Plaintiffs and Class members would clearly outweigh any potential harm to Medical Mutual from enjoining its misconduct.

149. No third parties will be harmed from granting Plaintiffs' requested injunctive relief.

150. The requested injunctive relief will serve the public interest because it will prevent Medical Mutual from continuing to defraud and wrongly overcharge Plaintiffs and Class members.

151. A preliminary and permanent injunction is needed to prevent the irreparable harm that Medical Mutual will cause by continuing its improper and fraudulent behavior.

152. Plaintiffs and Class members lack a plain, speedy or adequate remedy at law.

COUNT VI
(Declaratory Relief)

153. Plaintiffs reallege and incorporate by reference every allegation set forth in paragraphs 1 through 152 as if they rewrote these paragraphs here.

154. A genuine, ripe, and concrete controversy exists between Medical Mutual and Plaintiffs and Class members concerning Medical Mutual's wrongful and illegitimate charges.

155. This controversy is justiciable in character. Medical Mutual has engaged in and continues to engage in inequitable, unfair, and fraudulent conduct by defrauding Plaintiffs and Class members through charging and collecting improper and undisclosed charges related to Medical Mutual's value-based contracts as though these improper and undisclosed charges are Covered Services.

156. Speedy relief is necessary to preserve Plaintiffs' and Class members' rights that might be otherwise impaired or lost since Medical Mutual has committed and will continue to commit acts that will produce direct, immediate, and irreparable harm.

157. Plaintiffs and Class members have no plain, speedy, or adequate remedy at law.

158. The foregoing facts show that a substantial controversy exists between parties having adverse legal interests that are of sufficient immediacy and reality to warrant final declaratory relief.

159. Under R.C. 2721.02, this Court "may declare rights, status, and other legal relations[,] whether or not further relief is or could be claimed." Accordingly, Plaintiffs and Class members seek a declaration of the rights, status, and contractual obligations and entitlements of the parties under the law supporting the causes of action set forth above. By granting the requested declaratory relief, this Court will avoid multiple actions by declaring the litigants' rights and obligations in one action.

160. As demonstrated above, the Class is cohesive.

161. Plaintiffs and Class members request the Court's declaration that:

a. Medical Mutual is barred from charging and collecting from Plaintiffs and Class members any payments related to its value-based contracts, and

b. Medical Mutual is required to disgorge any money it has collected from Plaintiffs and Class members related to any value-based charges.

WHEREFORE, Plaintiffs, Lorain County, Ohio, City of Elyria, Ohio, and City of Lorain, Ohio, demand judgment in their favor against Defendants, Medical Mutual of Ohio and Medical Mutual Services, LLC, jointly and severally, for:

1. with respect to Count I, compensatory damages exceeding $25,000, to be determined at trial;

2. with respect to Count II, compensatory damages exceeding $25,000, to be determined at trial, and punitive damages exceeding $25,000, to be determined at trial;

3. with respect to Count III, disgorgement of Medical Mutual's ill-gotten proceeds, gains, and benefits;

4. with respect to Count IV, actual damages exceeding $25,000, to be determined at trial, under R.C. 4165.03(A)(2); injunctive relief under R.C. 4165.03(A)(1); and attorneys' fees under R.C. 4165.03(B) because of Medical Mutual's knowing and willful engagement in a trade practice listed in R.C. 4165.02(A);

5. with respect to Count V, a preliminary and permanent injunction:

   a. enjoining Medical Mutual from continuing to charge Plaintiffs and Class members for costs related to Medical Mutual's value-based contracts where their ASOs do not permit these charges;

   b. enjoining Medical Mutual from continuing to submit false and misleading statements to Plaintiffs and Class members;

   c. requiring Medical Mutual to report or disclose value-based charges in future contracts or addenda if Medical Mutual intends to charge these costs to Plaintiffs and Class members; and

   d. requiring disgorgement of Medical Mutual's ill-gotten proceeds, gains, and benefits;

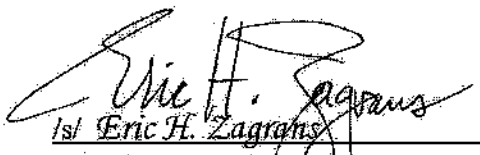
6. with respect to Count VI, a declaration that Medical Mutual was not entitled to charge Plaintiffs and Class members or to collect from them unauthorized payments related to undisclosed value-based contracts; that Plaintiffs and Class members should not have paid Medical Mutual for the costs of Medical Mutual's undisclosed value-based contracts; and that Medical Mutual must disgorge to Plaintiffs and Class members the money that Medical Mutual wrongfully collected from them related to its undisclosed value-based contracts;

7. prejudgment interest at the maximum rate allowed by law on each wrongful payment and postjudgment interest at the maximum rate allowed by law;

8. the costs of this action, including reasonable attorneys' fees;

9. an order certifying Plaintiffs' class as pleaded and appointing Plaintiffs' counsel as class counsel; and

10. such other and further relief as this Court may deem just and proper.



/s/ Eric H. Zagrans

Eric H. Zagrans (0013108)
ZAGRANS LAW FIRM LLC
6100 Oak Tree Boulevard, Suite 200
Cleveland, Ohio 44131
(216) 771-1000 (telephone)
eric@zagrans.com (e-mail)

and

Daniel R. Karon (0069304)
Beau D. Hollowell (0080704)
KARON LLC
700 West St. Clair Avenue, Suite 200
Cleveland, Ohio 44113
(216) 622-1851 (telephone)
dkaron@karonllc.com (e-mail)
bhollowell@karonllc.com (e-mail)

and

Joshua R. Cohen (0032368)
James B. Rosenthal (0062872)
Jason R. Bristol (0072989)
COHEN ROSENTHAL & KRAMER LLP
700 West St. Clair Avenue, Suite 400
Cleveland, Ohio 44113
(216) 781-7956 (telephone)
jcohen@crklaw.com (e-mail)
jrosenthal@crklaw.com (e-mail)
jbristol@crklaw.com (e-mail)

and

Jack Landskroner (0059227)
Drew Legando (0084209)
LANDSKRONER GRIECO MERRIMAN LLC
1360 West 9th Street, Suite 200
Cleveland, Ohio 44113
(216) 522-9000 (telephone)
jack@lgmlegal.com (e-mail)
drew@lgmlegal.com (e-mail)

and

R. Eric Kennedy (0006174)
Daniel P. Goetz (0065549)
WEISMAN KENNEDY & BARRIS, L.P.A.
101 West Prospect Avenue, Suite 1600
Cleveland, Ohio 44115
(216) 781-1111 (telephone)
ekennedy@weismanlaw.com (e-mail)
dgoetz@weismanlaw.com (e-mail)

and

Paul W. Flowers (0046625)
PAUL W. FLOWERS CO., L.P.A.
50 Public Square, Suite 1910
Cleveland, Ohio 44113
(216) 344-9393 (telephone)
pwf@pwfco.com (e-mail)

and

W. Craig Bashein (0034591)
BASHEIN & BASHEIN CO., L.P.A.
50 Public Square, Suite 3500
Cleveland, Ohio 44113
(216) 539-8437 (telephone)
wcb@basheinlaw.com (e-mail)

Attorneys for Plaintiffs and the Class

JURY DEMAND

Plaintiffs hereby demand a trial by jury under Rule 38 of the Ohio Rules of Civil Procedure, on all issues so triable.

/s/ Eric H. Zagrans
Eric H. Zagrans

Exhibit 1

MEDICAL MUTUAL SERVICES, L. L. C.

AGREEMENT

This Agreement is entered into between **The County of Lorain #443492** (the "Group") on behalf of itself and Medical Mutual Services, L. L. C. ("Medical Mutual Services").

The Effective Date of the Agreement is **January 1, 2010** at 12:01 a.m., regardless of the date executed by the parties.

RECITALS

A. The Group has established a benefit plan (the "Plan") for its eligible employees and their eligible dependents ("Covered Persons"); and

B. Pursuant to the Plan, the Group has agreed to provide certain benefits to Covered Persons; and

C. The Group has determined that it is advisable to establish an administrative relationship with Medical Mutual Services, located at 2060 East Ninth Street, Cleveland, Ohio 44115, to act as the claims administrator in (1) receiving and processing claims for benefits under the Plan; (2) disbursing claims payments under the Plan; and (3) performing such additional duties as set forth herein; and

D. The Group and Medical Mutual Services have determined that it is appropriate and necessary to enter into this Agreement to set forth the respective rights and obligations of the Group and Medical Mutual Services in connection with the administration of the benefits pursuant to the Plan.

Now, therefore, in consideration of the mutual promises, covenants and understandings contained herein, the Group and Medical Mutual Services hereby agree as follows:

PROVISIONS

ARTICLE I
DEFINITIONS

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

Section 1.2 **Benefit Books** - the applicable documents that describe the Covered Services, Benefits, eligibility requirements and other features and limitations of the Plan with respect to the Participants.

Section 1.3 **Confidential Information** - Any information regarding claims pricing, business practices, systems information, underwriting regulations or other know-how of Medical Mutual Services or any information specifically identified by Medical Mutual Services as proprietary information. The term also includes any individually identifiable information regarding Covered Persons, including medical information.

Section 1.4 **Covered Person(s)** - the Participant and the Participant's Eligible Dependent(s) as defined in the Benefit Book(s).

Section 1.5 **Covered Service(s)** - a Provider's service, supply or accommodation described in the Benefit Books, schedules of benefits, riders, addenda or Amendments.

Section 1.6 **Participant** – a person, employed by the Group who is eligible for and has elected to enroll in the Plan.

Section 1.7 **Provider** - a Hospital, Other Facility Provider, Physician or other Professional Provider as defined in the Benefit Books.

ARTICLE II
ADMINISTRATIVE OBLIGATIONS OF MEDICAL MUTUAL SERVICES

Medical Mutual Services shall perform all duties necessary and proper in connection with the processing of any payment of benefits, including, but not limited to, the following:

(1) Process and pay, according to the terms of this Agreement and the Benefit Books, claims incurred by Covered Persons and forwarded to Medical Mutual Services within the time periods specified in the Benefit Books and/or Addendum I.

(2) Notify Covered Persons whose request for benefits has been denied, including the reason for the denial. Such notice will include a general statement of the right to appeal and the name, address and phone number of the appropriate party to contact to initiate an appeal.

(3) Provide customer service functions for Covered Persons including the provision of direct toll-free telephone access to Medical Mutual Services for answers to questions about claims.

(4) If Medical Mutual Services determines or is subsequently informed in writing by the Group that it has paid any Provider more or less than the amount to which it is entitled under the Plan, Medical Mutual Services shall adjust the underpayment and recover the overpayment, except that Medical Mutual Services shall not be required to initiate court proceedings to recover the overpayments. Medical Mutual Services will cooperate with the Group if the Group initiates court proceeding to recover such over-payments.

(5) Provide coordination of benefits ("COB") and workers' compensation services.

(6) Provide subrogation services as part of its administration of claims under this Agreement. Medical Mutual Services will use a contracted vendor to pursue subrogation recoveries on a pay and pursue basis. The vendor will be responsible for sending letters and subrogation questionnaires to Covered Persons regarding potential subrogation claims. The vendor will also intervene in lawsuits where necessary. The subrogation vendor will begin investigation when the aggregate claims related to a subrogation case total $500 or more. However, if a case is brought to the attention of the vendor through another source, the vendor will investigate and pursue recovery of any amounts paid, regardless of the size of the claims. A fee based on a percentage of the recovery will be retained by the contracted subrogation vendor. All credits to the Group will be net of that fee.

(7) Prepare identification cards for delivery to the participants by the Group .

(8) Prepare and deliver Explanation of Benefits Forms ("EOBs") to participants.

(9) Maintain enrollment data with updates as received from the Group .

(10) Maintain and retain custody of the records of claims submitted under the Plan.

(11) Prepare and file Internal Revenue Form 1099 as necessary for Providers.

ARTICLE III
ADMINISTRATIVE OBLIGATIONS OF THE GROUP

Section 3.1 The Group is solely responsible for establishing and maintaining the Plan. The Group agrees that the Plan shall contain any provisions that are necessary to cause the Plan to be consistent with the provider network contracts. The Group shall be solely responsible for the final content of the Plan and any Summary Plan Description prepared by the Group, except that any references in the documents to Contracting Providers or to Medical Mutual Services or the network or services provided by Medical Mutual Services or the network must be approved in writing by Medical Mutual Services or the network before any distribution of the documents, including distribution to Covered Persons.

Section 3.2 The Group shall provide Medical Mutual Services with copies of any benefit descriptions or plan documents prepared by the Group and amendments thereto in a timely manner after adoption and execution of the same. The Group agrees that Benefit Books prepared by the Group may be reviewed by Medical Mutual Services to ensure compliance with Medical Mutual Services' claims processing procedures. If Medical Mutual prepares Benefit Books for the Group, this is not necessary. The Plan may be amended by the Group at its discretion. The Group shall give Medical Mutual Services written notice of any such amendment at least sixty (60) days before its effective date. It is the Group's obligation to notify Participants of any changes and the effective dates thereof and provide any required notice of changes in the plan. Any change in the nature of the services provided by Medical Mutual Services under this Agreement that would be caused by their amendment, must be approved in writing by Medical Mutual Services for the change in services to be included under this Agreement. Any such approved change shall also be a basis for Medical Mutual Services to request re-negotiation of the fee paid to Medical Mutual Services by the Group.

In the event the parties cannot agree on a new fee within thirty (30) days of the date Medical Mutual Services received written notice of the amendment, Medical Mutual Services shall have no obligation to provide the changed services and Medical Mutual Services may terminate this Agreement upon thirty (30) days prior written notice to the Group.

Section 3.3 The Group shall make the payments required by Addendum I attached hereto.

Section 3.4 If the Group has paid Medical Mutual Services funds under this Agreement that may be returned, in whole or in part, to the Group at some later time, including any advance deposit, claims payments and administrative fees, any income or interest Medical Mutual Services has received or may receive from these funds shall be for the sole benefit of Medical Mutual Services and shall be retained by Medical Mutual Services.

Section 3.5 The Group shall be financially liable for claims incurred by a Covered Person and paid by Medical Mutual Services prior to receipt from the Group of written or electronic notification of the termination of such Covered Person's enrollment in the Plan. In response to a written customer service inquiry by the Group, Medical Mutual Services will attempt to recoup payments made for former Participants who have been retroactively deleted from eligibility and credit the amounts recouped on the next billing cycle after the adjustment is processed.

Section 3.6 The Group shall use reasonable efforts to furnish promptly all information regarding the Plan and Covered Persons required by Medical Mutual Services to perform its obligations under this Agreement.

ARTICLE IV
TERMINATION

Section 4.1 The initial term of the Agreement shall be for a period of twelve (12) months beginning on the Effective Date (the "Initial Period"). Unless canceled or terminated earlier as provided for by this Agreement, the Agreement will renew for a further period of twelve (12) consecutive months and thereafter, from year to year through the Agreement Period ending on January 1, 2013 the "Projected Termination Date"). Renewal for each Agreement Period may be subject to new administrative fees as provided in Addendum I and any new performance guarantees.

The Group may cancel or terminate this Agreement without cause only upon thirty (30) days written notice to Medical Mutual Services. If the medical claims administration services performed by Medical Mutual Services pursuant to this Agreement are terminated by the Group and the Termination Effective Date is prior to the Projected Termination Date, the early termination penalty provisions set forth in Section 6 of Addendum I shall apply. Medical Mutual Services may cancel or terminate this Agreement at any time without notice if the Group fails to pay the amounts required by this Agreement. If, prior to the Projected Termination Date, Medical Mutual Services terminates this Agreement due to the Group's failure to pay the amounts required by this Agreement, the early termination penalty provisions set forth in Section 6 of Addendum I shall apply as if the Group terminated this Agreement. Medical Mutual Services' negotiation of any check sent or deposited into Medical Mutual Services' lockbox after the termination date does not constitute acceptance or reinstatement by Medical Mutual Services. Medical Mutual Services may also cancel or terminate this Agreement with thirty (30) days written notice in the event of fraud or misrepresentation by the Group.

Either party may terminate this Agreement in the event of a material breach of the terms of this Agreement by the other party, other than for a failure to pay as described in the immediately preceding paragraph. Such termination shall be effective thirty (30) days after written notice of the breach is delivered to the breaching party, unless the breach has been cured before the end of the thirty (30) day period. If, prior to the Projected Termination Date, either party terminates this Agreement due to a breach by the other party, the early termination penalty provisions set forth in Section 6 of Addendum I shall apply.

If the Agreement is terminated prior to the Projected Termination Date as a result of Group's filing of a petition for bankruptcy or liquidation, the early termination provisions set forth in Section 6 of Addendum I will apply.

If the Agreement is canceled or terminated, the Group must notify in writing all of its Participants of the cancellation or termination.

Section 4.2 Additionally, this Agreement shall automatically terminate as of the effective date of any legislative enactment which makes illegal the continuation of the Plan and/or this Agreement. Termination pursuant to this provision, if it occurs prior to the Projected Termination Date, will not trigger the early termination penalty provisions set forth in Section 6 of Addendum I.

Section 4.3 If the Group fails to make any payment required by this Agreement when due, Medical Mutual Services may suspend processing of claims commencing on the day after such payment was due.

Section 4.4 The Group shall be liable for all administrative fees and claim payments due to Medical Mutual Services upon termination of this Agreement, as specifically described in the attached Addendum I .

Section 4.5 If this Agreement terminates, any claims not paid as of the Termination Effective Date shall be administered as described in Addendum I, Section 5.

ARTICLE V
COVERAGE AND RIGHTS

Section 5.1 Medical Mutual Services as Payor

(a) Nothing in this Agreement shall have the effect of imposing upon Medical Mutual Services any obligation to provide any Covered Service, but only to administer benefits for Covered Services in consideration of the amounts paid by the Group under this Agreement.

(b) Medical Mutual Services shall not be considered the insurer or underwriter of the liability of the Group to provide benefits for Covered Persons. The Group shall be responsible for all expenses incident to the operation of its plan.

(c) Medical Mutual Services shall have no responsibility to process or pay claims for services that are not Covered Services except where instructed to do so by the Group.

(d) The method of calculations for deductibles, copayments, coinsurance and benefit maximums is set forth in Addendum III.

Section 5.2 Employee Retirement Income Security Act (ERISA)

The Group represents that it is a non-federal governmental plan and is therefore exempt from regulation under ERISA.

Section 5.3 Consolidated Omnibus Budget Reconciliation Act of 1986, As Amended (COBRA)

It is the responsibility of the Group to inform participants in the Plan of their COBRA mandated rights according to the provisions of COBRA, as amended, and to comply with all COBRA requirements outlined in the applicable Federal law. The Group agrees to use Medical Mutual Services' contracted COBRA administrator to comply with this provision.

Section 5.4 Health Insurance Portability and Accountability Act of 1996 (HIPAA)

(a) Medical Mutual Services will provide certificates of creditable coverage to individuals losing coverage under the Plan. Medical Mutual Services will provide such certificates only while this Agreement is in force. If this Agreement is terminated, no certificates will be issued by Medical Mutual Services except as requested by Covered Persons or the Group.

(b) Except as provided in Paragraph 5.4(a), it is the responsibility of the Group to provide any other notices required by HIPAA, , including notices to employees if the Group elects to be exempt from HIPAA or portions thereof. Should the Group elect an exemption under HIPAA it agrees to notify Medical Mutual at least 30 days in advance of the effective date of the exemption.

Section 5.5 Responsibility for Delay in Performance

Medical Mutual Services shall not be responsible for delay in the performance of this Agreement or for the nonperformance of this Agreement if the delay or nonperformance is caused by the failure of the Group or any participant to comply fully with Article III. The Group shall not be responsible for the delay in the performance of this Agreement or for the nonperformance of this Agreement if the delay or non-performance is caused by the failure of Medical Mutual Services to comply with Article II.

Section 5.6 Provider Agreements

Medical Mutual Services, through an affiliated company, negotiates agreements with providers and networks. These negotiations are undertaken on behalf of Medical Mutual Services, and not on behalf of the Group or the Plan. These negotiations and agreements are not a function Medical Mutual Services has undertaken or will undertake pursuant to this Agreement and Medical Mutual Services and the Group acknowledge that neither Medical Mutual Services nor its affiliates are fiduciaries when performing this function.

Medical Mutual Services has and retains the sole right to choose which Providers or networks it will contract with, and on what terms and to amend and terminate those agreements. Medical Mutual Services has and retains the sole right to designate Providers as contracting and/or network.

Section 5.7 Retention of Discretion

The Group shall have the exclusive right to interpret the terms of the Benefit Book(s) and any Amendments. The decision about whether to pay any claim, in whole or in part, is within the sole discretion of the Group and such decisions shall be final and conclusive, subject to any appeals process as outlined in the Benefit Book(s). Medical Mutual Services and the Group further agree that it is the intention of Medical Mutual Services and the Group that the Group's decision to grant or deny any benefit shall be given judicial deference in any suit for review or such grant or denial of any benefit.

Section 5.8 Limitation of Actions

Neither party may file suit against the other involving a dispute arising under this Agreement more than three (3) years from the date the cause of action arises.

ARTICLE VI
AUDITS AND RECORDS

Section 6.1 Cost Recovery Audits

Medical Mutual Services or a third party hired by Medical Mutual Services may perform random cost recovery audits, which do not relate to any specific group. Where there is an adjustment to a specific claim, as a result of the audit, it will be credited to the Group. The credit will be shown on the Group's invoice as a claim adjustment. For certain recoveries where Medical Mutual Services is not responsible for the overpayment and the Medical Mutual Services claims processing system could not stop the overpayment, the cost of the recovery will be included on the Group's monthly invoice. This charge will reflect the percentage of the recovery that is paid to the auditing firm. In no case shall any cost be charged to the Group for any audit performed pursuant to this Section 6.1 for which no recovery is made. In some instances, the claim recovery will be net of the cost of the recovery. In that instance the cost will be subtracted from the credit and no separate charge will be passed on to the Group.

The Group may request that Medical Mutual Services perform specific audits of certain classes or types of claims made by or payments made on behalf of the Group's Covered Persons and Medical Mutual Services will do so for a reasonable fee. Any recoveries which Medical Mutual Services may receive as a result of a Group requested audit shall be credited to the Group's account less the amount of Medical Mutual Services' fee.

Section 6.2 Records Retention

Medical Mutual Services shall maintain, in a form deemed appropriate by Medical Mutual Services, records relating to its responsibilities under this Agreement, including records relating to claims processing. Medical Mutual Services shall retain such records for not less than seven (7) years.

Group shall maintain records relating to the terms and operation of the Plan, including the identification of eligible persons, payments to Medical Mutual Services and payments for Covered Services. The Group shall maintain such records for a period of not less than seven (7) years.

Pursuant to paragraph 6.3 below, each party may have access to the records directly and specifically relating to the Plan and maintained by the other party, during normal business hours and upon reasonable notice, provided, however, that Medical Mutual Services shall not have to disclose provider payment fee schedules or other proprietary information. Each party shall pay the cost of copies of any records that it requests from the other party.

Section 6.3 Group's Right to Audit

The Group shall have the right to audit, once per calendar year, the claim records of Medical Mutual Services pertaining to this Agreement and any payments made hereunder. The Group may only audit Incurred Claims for the previous two Agreement periods. The Group may also perform such audits during the two year period following termination of this Agreement. Any requested audit following the two year period must be by mutual agreement and will be subject to a reasonable fee. The purpose of such an audit is to provide assurance to the Group that the Group's claims are being processed and paid in accordance with the terms of this Agreement and the Benefit Book(s). The Group agrees to provide Medical Mutual Services with at least 60 days notice prior to any planned audit. The Group specifically acknowledges that Medical Mutual Services may only agree to an audit of its own records and in no way does this Agreement give the Group a right to audit the records of any person or entity not a party to this Agreement, nor does Medical Mutual Services represent that it can give the Group such a right.

The Group may hire a mutually agreeable third party auditing firm to conduct the audit of records described above. The Group must provide Medical Mutual Services with written authorization to allow the auditor to have access to Plan records. Such auditing firm must execute a confidentiality agreement in substantially the form of Addendum II, with Exhibits, prior to any data being released to the auditor. The audit must be conducted in accordance with Medical Mutual Services' corporate audit procedures, a copy of which will be provided to the Group or Auditor upon request.

If the Group requests that Medical Mutual Services provide data to any other third party for purposes other than an audit of claims, the Group must provide Medical Mutual Services with a written request for release of such data. The third party receiving the data must execute an appropriate confidentiality agreement if the data request contains any Confidential Information. Depending on the nature of the request, Medical Mutual Services may require payment of a fee prior to the release of the data.

Medical Mutual Services makes no representation or warranty as to the accuracy or reliability of any conclusions or interpretations made by any person reviewing the claims data.

Section 6.4 Confidentiality

During the term of this Agreement, Group may be given access to Confidential Information in the form of reports, billing statements, information from audit reports, and other data requests made by the Group. The Group shall maintain the confidentiality of the Confidential Information and may not disclose the Confidential Information to any person or entity outside of Medical Mutual Services or the Group, except those auditors or consultants of the Group who have signed a Confidentiality Agreement as referenced above.

During the term of this Agreement, the parties may also be given access to individually identifiable health information that is considered private, privileged and confidential. Such information is deemed to be Covered Information for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), P.L. 104-191. The parties are required to, and hereby agree to, maintain the private, privileged and confidential status of the Covered Information. The parties also agree to use the information only for those purposes enumerated in this Agreement as required by HIPAA. In addition, if a party discloses any Covered Information to a business partner (following written permission) pursuant to a written contract, the written contract shall meet the requirements of HIPAA.

The parties may also be given access to non-public personal information about consumers that is considered private. Such information is deemed to be protected by the Gramm-Leach-Bliley Act, P.L. 106-102 (the "GLB Act"). The parties are required to, and hereby agree to, maintain the private status of such information.

Neither the Group nor any of its agents shall contact any provider concerning any Confidential Information, unless said contact is conducted with the express written consent of Medical Mutual Services.

Medical Mutual Services shall maintain the confidentiality of all claims data related to the Plan and may not disclose it to any person or entity outside of Medical Mutual Services or the Group, except those auditors or consultants of the Group who have signed a Confidentiality Agreement as referenced above.

Nothing herein shall be construed to prohibit the Group's disclosure of aggregate payment and utilization data to any existing or prospective stop-loss insurer or to any prospective third party administrator ("TPA") or insurance carrier for the purpose of facilitating a proposal from such TPA and/or insurance carrier to administer or insure the Group's health care benefits.

Subject to the confidentiality provisions of this section, the Group shall have the right to obtain copies, upon termination of this Agreement, of claim records maintained by Medical Mutual Services or supplied to Medical Mutual Services by the Group. Medical Mutual Services shall also have the right to retain copies of all such records.

ARTICLE VII
COST MANAGEMENT PROGRAMS

The Group agrees to cooperate with Medical Mutual Services and Providers in cost management and utilization programs which Medical Mutual Services implements from time to time, such as preadmission certification, concurrent review, case management and other carrier liability programs to the extent that these programs do not conflict with the Plan documents.

The Group shall inform eligible Participants of the requirements of Medical Mutual Services' applicable network programs and assist Medical Mutual Services 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 maintain and set forth in its Benefit Books an incentive plan reasonably calculated to encourage eligible participants and their Eligible Dependents to utilize network providers.

ARTICLE VIII
MISCELLANEOUS

Section 8.1 Changes to the Agreement

No change in the Agreement will be effective until approved in writing by an authorized officer of Medical Mutual Services and the Group . This approval must be endorsed on or attached to the Agreement. No agent, employee or representative of Medical Mutual Services or the Group , other than an authorized officer, may change this Agreement or waive any of its provisions. Medical Mutual Services and the Group shall use best efforts to act on a requested change within thirty (30) days of receipt of the request; however, failure to respond within this time frame shall not automatically validate the request.

Section 8.2 Amendments

The terms and conditions of this Agreement may be amended at any time by mutual written agreement of Medical Mutual Services and the Group. It is the responsibility of the Group to notify Covered Persons of any changes in the terms or conditions of this Agreement.

Section 8.3 Notice

Any notice required under this Agreement 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. Notice to Medical Mutual Services must be hand-delivered or mailed by first class mail with proper postage, to Medical Mutual Services at Medical Mutual Services' address stated. Notice shall be deemed effectively received on the date of delivery or three (3) days after the date of post mark, whichever is earlier. The Group or Medical Mutual Services may, by written notice, indicate a new notice address.

Section 8.4 Legal Actions

The parties shall use reasonable care and due diligence in the exercise of their powers and the performance of their duties under this Agreement.

The defense of any legal action against the Group or the Plan on a claim for benefits under the Plan shall not be an obligation of Medical Mutual. The defense of any legal action against Medical Mutual Services regarding its actions under this Agreement shall not be an obligation of the Group. However, Medical Mutual Services and the Group shall have the right to participate in the defense of such actions if they so choose, at their own expense. The parties to this Agreement shall cooperate with each other by furnishing such evidence as each has available in connection with the defense of any such actions.

Section 8.5 Severability

If any provision or any part or any application of this Agreement 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.

Section 8.6 Governing Law

This Agreement shall be governed by and construed in accordance with the laws of the state of Ohio and all applicable Federal laws and regulations.

Section 8.7 Entire Agreement

The terms and provisions of this Agreement set forth the entire understanding of the parties and will not be changed other than by a written agreement executed by both parties pursuant to Section 8.2.

Section 8.8 Assignment

No assignment of the Group's interests under this Agreement shall be binding upon Medical Mutual Services unless Medical Mutual Services agrees in writing.

Section 8.9 Counterparts

This Agreement may be executed concurrently in multiple counterparts, each of which shall be deemed an original, but all of which taken together shall constitute one and the same instrument.

Section 8.10 Exclusivity

Group agrees that the self funded health plan administered by Medical Mutual Services shall be the only group health plan (other than a flexible spending account) offered to Covered Persons during the term of this Agreement and Group shall not enter into an agreement with any other third party administrator or insurer to provide or administer health benefits on behalf of Covered Persons. Should Group violate this section of the Agreement, the early termination penalty provisions set forth in Section 6 of Addendum I shall apply as of the first date that Medical Mutual Services is not the exclusive administrator of health benefits provided to the Group.

Section 8.11 Order of Preference

In the event of a conflict between this Agreement and the applicable Benefit Book, this Agreement shall govern.

IN WITNESS WHEREOF, Medical Mutual Services and the Group have signed this Agreement to be effective on the Agreement Date first above written.

The County of Lorain #443492
(The Group)

E C Blair
Signature

PRESIDENT,
LORAIN COUNTY BOARD OF COMMISSIONERS
Title

JUL 28 2010
Date

Medical Mutual Services, L. L. C.
(Medical Mutual Services)

Signature

Title

Date

APPROVED AS TO FORM
DATE 7/27/10
Dennis P. Will, Lorain County Prosecutor
By: [signature] ADA
Assistant County Prosecutor

ADDENDUM I
ASO WEEKLY INVOICING

This Addendum to the Agreement between **The County of Lorain #443492** (the "Group") and Medical Mutual Services, L. L. C. ("Medical Mutual Services") is an amendment to the Agreement and supersedes any prior invoicing Addendum and has been adopted pursuant to the section of the Agreement entitled "Amendments".

Section 1: Definitions

A. Agreement Period: Each twelve month period that this Agreement is in effect, beginning with the initial Period beginning January 1, 2010. The parties may extend the Agreement past the Projected Termination Date upon mutual consent.

B. Projected Termination Date. The last day of the last Agreement Period, as negotiated between the parties, upon which the Agreement shall terminate automatically with no further automatic renewal, as provided in Article IV of the Agreement, irrespective of whether the parties have agreed to extend the Agreement Period. The Projected Termination Date of the Agreement shall be January 1, 2013.

C. Incurred Claim: A claim for Covered Services, as defined in the applicable Benefit Book(s), that has beginning service dates on or after the effective date of the Agreement and prior to the Termination Effective Date of the Agreement.

D. Adjudicated Claim: An Incurred Claim which has been processed and approved for payment but has not been released for payment by Medical Mutual Services.

E. Paid Claim: An Adjudicated Claim for which Medical Mutual Services has reimbursed the Provider or Participant on behalf of the Group. A claim is considered a Paid Claim as of the date shown on the check written by Medical Mutual Services. Claim Amounts will be paid in accordance with Medical Mutual Service's claims disbursement schedule.

F. Paid Claim Amount: The amount Medical Mutual Services pays to the Provider or the Participant for the individual claim, after the claim has been adjudicated and released for payment.

(i) For claims at hospitals and other institutions, the Paid Claim Amount shall not include adjustments or settlements due to maximum charge increase limitation violations, prompt payment discounts, or any settlement, incentive, allowance or adjustment that does not accrue to a specific claim at the time of adjudication.

(ii) For claims involving physicians or other professional providers, the Paid Claim Amount is not reduced by performance withholds.

(iii) For claims involving prescription drugs dispensed for use, the Paid Claim Amount does not include any formulary reimbursement savings, volume-based credits or refunds or discount guarantees.

(iv) In certain circumstances, Medical Mutual Services, through an affiliated company, may have an agreement or arrangement with a vendor which purchases services, supplies or products from Providers instead of Medical Mutual Services contracting directly with Providers themselves. Medical Mutual Services' agreement or arrangement with that vendor may not include the vendor's purchase price from the Provider, but may be based on some other financial arrangement such as a guaranteed discount.

The Paid Claim Amounts, in these circumstances, will be based on the network's re-pricing agreement with the vendor and not upon the vendor's actual purchase price with the Provider, subject to any further conditions or limitations set forth herein. Vendors include, but are not limited to, pharmacy providers, other managed care providers, home health providers and other provider networks.

(v) When the Covered Person receives services outside of the State of Ohio the claims for Covered Services will be processed whenever possible through a vendor relationship with another provider network with which Medical Mutual Services has contracted. The Paid Claim Amount for a claim submitted by an out of state provider will be based on the contractual arrangement the provider has with the network program. If the Plan's primary network does not have an arrangement with the provider, Medical Mutual Services will attempt to arrange for a discount through a secondary network. In such cases, any fees to obtain the discount will be included in the Paid Claim Amount. If there is no Agreement with a network provider, the Paid Claim Amount will be based on Net Covered Charges. The Group shall not be entitled to any further reduction or adjustment in the price of the claim other than what Medical Mutual Services receives from the network program.

G. Covered Charges: the charges for Covered Services, as defined in the applicable Benefits Book(s).

H. Net Covered Charges: Covered Charges less any deductibles, copayments, coinsurance or other patient liabilities and any amounts paid by other parties resulting from coordination of benefits, subrogation, workers' compensation and other party liability.

I. Administrative Fee: The monthly amount paid to Medical Mutual Services by the Group to cover administrative and other expenses per Participant per month. The Administrative Fee is specified in Exhibit A and will increase at each annual renewal by no more than the increase in the CPI-U, subject to the provisions of Section 4, Paragraph B of this Addendum I.

J. Discounted Fee: the Administrative Fee for the current Agreement Period minus a 20% discount.

K. Waived Fee Amount: the difference between the Administrative Fee and the Discounted Fee.

L. Provider Discount: Net Covered Charges minus the Paid Claim Amount.

M. Guaranteed Minimum Provider Discount: The minimum percentage of savings for the non-Medicare Paid Claim Amounts guaranteed by Medical Mutual Services for the Agreement Period. The Guaranteed Minimum Provider Discount, by lines of business, is shown on Exhibit A.

The Guaranteed Minimum Provider Discount shall be settled annually within four (4) months following the end of the Agreement Period. If the Plan Sponsor's savings for the Agreement Period is less than the Guaranteed Minimum Provider Discount, Medical Mutual shall issue a check to the Plan Sponsor for the difference, not to exceed the amount of the Guaranteed Minimum Provider Discount. Savings in excess of the Guaranteed Minimum Provider Discount shall be retained by the Plan Sponsor.

N. Out of State Surcharges: The States of New York and Massachusetts have enacted legislation which imposes surcharges on certain health care costs incurred by Covered Persons receiving services in those states. Medical Mutual Services will pay the Out of State Surcharges directly to each state for the Group. The Group will be invoiced for actual Out of State Surcharges paid by Medical Mutual Services. Payment is due in accordance with the terms of the invoice. No additional Administrative Fee will be charged for this service. The same procedure will apply if other states pass similar legislation.

O. Termination Effective Date: 12:01 a.m. on the date the Agreement terminates for the group, any line(s) of business or any section(s) thereof, as specified pursuant to a written termination notice from one party to the other.

P. Access Fees: Amounts paid to Medical Mutual Services and/or the provider network(s) by the Group for use of the provider network(s).

Section 2: Invoicing

A. Weekly Invoices: Throughout the Agreement Period Medical Mutual Services shall invoice the Group each week for claims paid by Medical Mutual Services during the preceding week, and for Stop Loss credits as notified by the Stop Loss carrier. The Group will pay the invoiced amounts on the second business day following the date of the invoice. If payment of the invoice is not received when due, Medical Mutual Services will suspend processing of the group's claims and will not release future claim payments until payment is received from the Group.

B. Monthly Invoices: Throughout the Agreement Period Medical Mutual Services shall issue on a monthly basis an invoice for the Administrative Fee and for Stop Loss Premiums, on behalf of the Stop Loss Carrier. The invoice shall include the Discounted Fee as shown on Exhibit A presently due and payable.

In addition, Medical Mutual Services shall issue a separate invoice on a monthly basis for the month's claims less amounts paid for weekly invoices for the month. Payment for each monthly invoice will be due to Medical Mutual Services on the first of each month or within ten (10) days of the date of the invoice, whichever is later. If the invoice is not paid when due, Medical Mutual Services will suspend payment of the group's claims and will not release future claim payments until payment is received from the Group.

C. Without waiving any other remedies Medical Mutual Services may have for non-payment or late payment by the Group of any amounts billed by Medical Mutual Services, including, but not limited to, Claims, Monthly Invoices and Out of State Surcharges, Medical Mutual Services reserves the right to change the Plan's claims invoicing method, described in 2A above, and will bill for claims adjudicated rather than claims paid. This means that Medical Mutual Services will invoice the Group for claims that are ready to be paid, but will not release those payments until funds for such claims are received from the Group. The change to an adjudicated invoicing method will commence immediately upon notification to the Group.

D. Medical Mutual Services, through an affiliated company, has Agreements with Providers, including hospitals. Some of these Agreements with Providers allow discounts, allowances, incentives, adjustments and settlements. These amounts are for the sole benefit of Medical Mutual Services and Medical Mutual Services will retain certain of the payments resulting therefrom as more fully set forth in Section 1F hereof. In any event, however, Paid Claim Amounts shall be calculated as provided herein, and deductibles, copayments, coinsurance and benefit accumulations shall be calculated as set forth in Addendum III or the Benefit Book(s).

E. The Group acknowledges and understands that the Paid Claim Amount may exceed the amount of Net Covered Charges for the Covered Services and that some of its payment responsibilities are nevertheless based on the Paid Claim Amounts and not upon the lesser of Net Covered Charges or the Paid Claim Amount.

Section 3: Management Reports

Medical Mutual Services shall prepare the following standard management reports for the Group:

Monthly Claims Detail
Annual Renewal Package
Quarterly Reporting Package

Reports or analyses not listed herein may be provided by Medical Mutual Services for a reasonable fee upon request of the Group.

Section 4: Changes to the Funding Arrangement

A. At least thirty (30) days prior to the renewal date of the Agreement, Medical Mutual Services will notify the Group of any changes in the Administrative Fees, Access Fees or other fee(s) and Agreement terms.

B. Medical Mutual Services reserves the right to adjust the fees, premiums and liability limits for the Agreement Period if the group's monthly enrollment changes, either in aggregate or for a specific line of business, by ten percent (10%) from the expected monthly enrollment specified in Exhibit A. Any adjustment in fees or liability limits will be effective as of the date of the change in enrollment. If, during any Agreement Period the Group's total enrollment for the medical line of business decreases by fifty percent (50%) or more from the expected enrollment set forth on the applicable Exhibit A to Addendum I for the Agreement Period, such decrease in enrollment will be deemed to be a termination of the Agreement by the Group and the provisions set forth in Section 6 below will be applicable.

Section 5: Termination

If the Agreement terminates for the group, line(s) of business or any section(s) thereof:

A. Medical Mutual Services will continue to process Incurred Claims where the incurred date(s) preceded the Termination Effective Date and which were received by Medical Mutual Services in accordance with the Group's applicable Benefit Book(s) and this Addendum I.

B. For the first twelve (12) weeks following the Termination Effective Date, Medical Mutual Services shall continue to invoice the Group weekly as described in Section 2A of this Addendum I.

C. After the first twelve weeks following the Termination Effective Date, Medical Mutual Services will invoice the Group for Paid Claims monthly or less frequently, through the twelfth (12th) month after the Termination Effective Date. Payment of each invoice is due within ten (10) days of the date of the invoice.

D. Following the Termination Effective Date, Medical Mutual Services will continue to invoice the Group for Out of State Surcharges and Access Fees.

E. Medical Mutual Services will not process, pay or adjust any claims after the twelfth (12th) month following the Termination Effective Date and any claims submitted thereafter, if payable, in whole or in part, under the applicable Benefit Book(s) or Certificate(s) shall be the Group's payment responsibility solely and shall not be a liability of Medical Mutual Services.

F. Following the Termination Effective Date, if Medical Mutual Services receives any checks for payment of subrogation claims, Medical Mutual Services will forward those amounts to the Group, less any amounts related to the third party claim paid under applicable stop loss insurance for the Covered Person.

G. For three consecutive months following the Termination Effective Date, Medical Mutual Services will invoice the Group for the Administrative Fee per Participant times the greater of the number of Participants in effect in each applicable section at the Termination Effective Date or the average number of Participants in effect in each applicable section for the three (3) months immediately prior to the Termination Effective Date. The Group shall pay the invoiced amounts within ten (10) days of the date of each invoice.

H. If the Group does not pay any invoiced amount due on the date specified for payment, Medical Mutual Services may suspend payment of claims and any other responsibilities it may have after the Termination Effective Date until payment is received.

Section 6: Early Termination Penalty

Waived Fee Amount: If the Group terminates the entire Agreement, for any reason, and the Termination Effective Date is prior to the Projected Termination Date, the Group shall pay to Medical Mutual Services the total cumulative Waived Fee Amount, calculated as of the last day of the month immediately preceding termination. The cumulative Waived Fee Amount shall be calculated by multiplying the Waived Fee Amount by the number of Participants enrolled during each month that the contract has been in effect.

Provided the Group does not terminate the entire Agreement on a Termination Effective Date prior to the Projected Termination Date, all rights of Medical Mutual Services under the Agreement with respect to the Waived Fee Amount shall be automatically extinguished, without further action by either party hereto, on the Projected Termination Date.

The Group represents and warrants that it has made or will make any appropriations necessary to effectuate payment of any applicable early termination penalty.

IN WITNESS WHEREOF, the Group and Medical Mutual Services have signed this Addendum I:

County of Lorain
(the Group)

Signature
PRESIDENT,
LORAIN COUNTY BOARD OF COMMISSIONERS
Title

JUL 28 2010
Date

Medical Mutual Services, L.L.C.
(Medical Mutual Services)

Signature

Title

Date

APPROVED AS TO FORM
DATE 7/27/10
Dennis P. Will, Lorain County Prosecutor
By: Assistant County Prosecutor

MEDICAL MUTUAL SERVICES, L.L.C.
EXHIBIT A-I
to
Addendum I
for
County of Lorain
Group Number: 443492

January 1, 2010 through December 31, 2010

	Administrative Fees per Participant per Month	Discounted Fees per Participant per Month
Medical:	$36.05	$28.84
Commission:	$ 2.50	$ 2.50

Guaranteed Minimum Provider Discount: The Guaranteed Minimum non-Medicare medical Provider Discount will be 54.0%. Medical Mutual will return five percent of the group's paid Discounted Fees, to a maximum penalty of 25 percent of the paid medical Discounted Fees for each one full point the actual Provider Discount falls below the guarantee. The Provider Discount may be negotiated annually at each renewal.

Prisoners Section 003 Medical Administrative Fee: 25% of the Provider Discount.

January 1, 2011 through December 31, 2011

	Administrative Fees per Participant per Month	Discounted Fees per Participant per Month
Medical:	$36.05	$28.84
Commission:	$ 2.50	$ 2.50

January 1, 2012 through December 31, 2012

	Administrative Fees per Participant per Month	Discounted Fees per Participant per Month
Medical:	$36.05 + cpi-u	80% of Administrative Fee
Commission:	$ 2.50	$ 2.50

Expected Monthly Enrollment: 1,862

- Group will be invoiced for the Discounted Fees
- cpi-u is not capped
- cpi-u floor is 0%
- Commission is not discounted and may be subject to change

ADDENDUM II

CONSULTANT/AUDITOR CONFIDENTIALITY/INDEMNIFICATION AGREEMENT

This Agreement is entered into by and between Medical Mutual Services, L. L. C.("Medical Mutual Services") and _____ ("Consultant") this _____ day of _____, 20__.

WHEREAS, Medical Mutual Services and _____ (the "Group") have previously entered into an Agreement for the administration of health care benefits; and

WHEREAS, the Group has requested that Medical Mutual Services make available to Consultant on-site access to certain confidential and/or proprietary information, including but not limited to material relating to the business of Medical Mutual Services, claims information, computer system information, medical records and financial information, in unscrambled form, regarding claims adjudication and payment during the period of _____ (the "Confidential Information"). A copy of the request for the Confidential Information is attached to this Agreement as Exhibit "A" and incorporated herein by reference; and

WHEREAS, Consultant represents that the request for the Confidential Information is for the purpose of reviewing claims processing and cost containment measures and is reasonably necessary to the protection or furtherance of such legitimate and lawful business purposes of the Group; and

WHEREAS, the parties to this Agreement undertake to preserve and protect the confidentiality of the Confidential Information.

NOW THEREFORE, in consideration of Medical Mutual Services' compliance with Group's request for the Confidential Information and other good and valuable consideration, the receipt of which is hereby acknowledged, the parties hereby agree as follows:

1. Medical Mutual Services will disclose and/or make Confidential Information related to Medical Mutual Services' administration of the Group's claims available for on-site review and/or audit by Consultant.

2. Consultant, on behalf of itself and its employees and agents, will maintain the confidentiality of the Confidential Information subject to the terms of this Agreement.

3. Medical Mutual Services makes no representation or warranty as to the accuracy or reliability of any conclusions or interpretations made by Consultant from the Confidential Information.

4. Consultant will use the Confidential Information only for the purpose of reviewing Medical Mutual Services' claims processing and cost containment measures with respect to the Group's claims, and will not use the Confidential Information for any other purpose.

5. Consultant will not divulge, broadcast, publish, or disseminate the Confidential Information to any person or entity other than the Group and/or Medical Mutual Services unless specifically authorized to do so in writing by a duly authorized representative of Medical Mutual Services. Notwithstanding the foregoing, Consultant will not disclose the data and/or information described in Paragraph 9 below to the Group.

6. Each employee and agent of Consultant who will have on-site access to the Confidential Information or access to work papers, notes, conclusions or reports derived from or based on Confidential Information shall execute a Confidentiality Statement in the form attached hereto as Exhibit B.

7. Neither Consultant, nor any of its employees or agents will contact any health care provider concerning the Confidential Information, unless such contact is with the express written consent of Medical Mutual Services.

8. All reviews of the Confidential Information will be conducted within the scope of the review mutually agreed upon by Consultant and Medical Mutual Services and outlined in Exhibit "A" and in accordance with this Agreement, and any additions or changes thereto must be submitted in writing to Medical Mutual Services for approval prior to implementation. Consultant agrees to provide Medical Mutual Services with a draft of the audit findings ten days prior to release to the Group in order to provide Medical Mutual Services the opportunity to comment on the findings.

9. Consultant acknowledges that Confidential Information to which Consultant, in the course of an on-site audit will have access to, may include data identifying the network or other discounts at a specific hospital(s) or other providers. Consultant shall not disclose any data or information to the Group or any other person whether in the form of notes, work papers, conclusions or report(s) which would allow, either directly or indirectly, the determination of network rates at a specific hospital(s) or other providers and will not use such information for any purpose other than this specific review or audit.

10. Consultant, on behalf of itself and its employees and agents, will indemnify and hold Medical Mutual Services harmless from loss, damage, or liability that Medical Mutual Services may suffer by reason of: (a) a breach of this Agreement; (b) the failure to obtain appropriate Confidentiality Statements as described in Paragraph 6 above; or (c) the provision of the Confidential Information to Consultant or the use of the Confidential Information by its employees or agents. The duty to indemnify Medical Mutual Services will survive this Agreement.

11. Consultant will reimburse Medical Mutual Services for all expenses, attorney's fees and costs incurred by Medical Mutual Services in any suit related to the enforcement of this Agreement where a judgment is rendered against Consultant or Consultant is ordered to pay damages or to specifically perform this Agreement.

12. Medical Mutual Services will provide Consultant with thirty (30) days' notice of any claim made against Medical Mutual Services for which Consultant is or may be liable to indemnify Medical Mutual Services.

13. This Agreement will inure to the benefit of and be binding upon all successors and assignors of the parties hereto.

14. Each provision of this Agreement, and any attachments hereto, shall be interpreted to be effective and valid under applicable law, but if any provision of this Agreement, or any attachment hereto, is prohibited or invalid under applicable law, then such provision will be ineffective only to the extent of such prohibition or invalidity without invalidating the remainder of this provision or the remaining provisions of this Agreement, or any attachment hereto.

15. The validity, interpretation and enforcement of this Agreement shall be governed by the laws of the State of Ohio.

EXHIBIT A to Addendum II

(***Request For Information and statement of scope of audit to be attached***).

EXHIBIT B to Addendum II

CONFIDENTIALITY STATEMENT

I have been advised and understand that Medical Mutual Services, L. L. C.("Medical Mutual Services") has an Agreement with _____ (the "Group") to administer health care benefits and that the Group requested certain information in order to conduct a review and/or audit of claims processing during the period of _____ (the "Review"). I further understand that such information is confidential and/or proprietary ("Confidential Information"). For the purpose of this Confidentiality Statement, Confidential Information includes any material not generally publicly available relating to the business of Medical Mutual Services, claims information, computer system information, medical records and financial information.

I will not disclose Confidential Information to anyone who is not an employee or agent of MEDICAL MUTUAL SERVICES or the Group, nor to any employee or agent of Consultant except those who have executed a Confidentiality Statement; nor am I to use the Confidential Information in any manner or for any purpose other than the above referenced Review. To the extent that the Confidential Information includes hospital specific discount information, I will not disclose such information to the Group or use it for any purpose other than this specific Review.

ADDENDUM III

DEDUCTIBLES, COPAYMENTS, COINSURANCE AND BENEFIT MAXIMUMS

This Addendum amends the Agreement and has been adopted pursuant to the Section of the Agreement entitled "Amendments".

During the Agreement Period, Medical Mutual Services will calculate deductibles, copayments, coinsurance and maximum benefit accumulations as set forth herein.

I. DEFINITIONS

A. Billed Charges: charges for all services and supplies that the Covered Person has received from a Provider whether they are a Covered Service or not.

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

C. Covered Charges: the Billed Charges for Covered Services, except that Medical Mutual Services reserves the right to limit the amount it will reimburse for Covered Charges for services provided by a non-contracting hospital or other institutional provider.

D. Covered Service: a Provider's service or supply for which benefits are to be provided as described in the Benefits Book(s) and Amendments

E. Lesser Amount: for contracting and participating Providers, the Lesser Amount means the lesser of the Negotiated Amount or the Covered Charges. For non-participating physicians and Other Professional Providers, the Lesser Amount means an allowable amount as determined by Medical Mutual Services. (The allowable amount will never exceed the Covered Charges.)

F. Negotiated Amount: the amount the contracting or participating Provider has agreed with Medical Mutual Services to accept as payment in full for Covered Services.

(i) The Negotiated Amount for institutional providers, including hospitals, does not include adjustments and/or settlements due prompt payment discounts, guaranteed discount corridor provisions, maximum charge increase limitation violations or any settlement, incentive, allowance or adjustment that does not accrue to a specific claim after the claim has been adjudicated.

(ii) The Negotiated Amount for participating physicians and Other Professional Providers does not include any performance withhold adjustments.

(iii) The Negotiated Amount for prescription drugs does not include any share of formulary reimbursement savings, volume based credits or refunds or discount guarantees.

(iv) In certain circumstances, Medical Mutual Services, through an affiliated company may have an agreement or arrangement with a vendor which purchases the services, supplies or products from Providers instead of Medical Mutual Services contracting directly with the Providers themselves. Medical Mutual Services' agreement or arrangement with that vendor may not include the vendor's purchase price from a Provider, but may be based on some other financial arrangement such as a guaranteed discount. The Negotiated Rate in these circumstances will be based upon the agreement or arrangement Medical Mutual Services has with the vendor and not upon the vendor's actual negotiated price with the Provider, subject to the further conditions and limitations set forth herein. Vendors include, but are not limited to, pharmacy providers, other managed care companies, home health providers and other provider networks.

(v) When the Covered Person receives services outside of the State of Ohio the claims for Covered Services will be processed whenever possible through a vendor relationship with another provider network with which Medical Mutual Services has a contract. The price for the claim submitted by an out of state provider will be based on the contractual arrangement the provider has with the network program or, if there is no contract with a network provider, on the Net Covered Charges. Medical Mutual Services will base its calculation of the amount payable for the claim on the price provided by the network program, including any access fees.

Deductibles, copayments, coinsurance and benefit maximums will be calculated according to the lesser of the amount Medical Mutual Services pays the network program or the Billed Charges.

II. CALCULATION METHODOLOGY

Medical Mutual Services shall calculate deductibles, copayments, coinsurance and benefit maximum accumulations based on the Lesser Amount, except that for hospitals and other institutional Providers with whom Medical Mutual Services through an affiliated company has no contract, Medical Mutual Services shall calculate deductibles, copayments, coinsurance and benefit maximum accumulations based on Covered Charges. Deductibles, copayments, coinsurance and amounts paid by other parties do not accumulate toward benefit maximums.

III. BENEFIT BOOK OR CERTIFICATE: Method of Calculation Provision

The Benefit Book(s) shall contain a provision setting forth the method by which deductibles, copayments, coinsurance and benefit maximum accumulations are calculated and that provision shall conform with this Addendum and incorporate its terms.

In inserting such a provision into the Benefit Book or Certificate, the Group shall also provide the following statement:

Medical Mutual Services through an affiliated company has agreements with Providers, including hospitals. Some of these agreements allow discounts, allowances, incentives, adjustments and settlements. These amounts are for the sole benefit of Medical Mutual Services and Medical Mutual Services will retain any payments resulting therefrom; however, the deductibles, copayments, coinsurance and benefit maximum accumulations shall be calculated as described in this Addendum or in the Benefit Book or Certificate.

IV. NOTICE TO PARTICIPANTS

The Group shall inform Participants about the method of calculation for deductibles, copayments, coinsurance and benefit maximum accumulations and Medical Mutual Services authorizes the Group to provide a copy of this Addendum to Participants for such purposes.

AMENDMENT

to the Administrative Services Agreement for
The County of Lorain

This Amendment modifies the Administrative Services Agreement (the Agreement), dated January 1, 2010, entered into between **The County of Lorain #443492** (the "Group") and Medical Mutual Services, L.L.C. (Medical Mutual Services).

The Effective Date of this Amendment is **January 1, 2013** at 12:01 a.m., regardless of the date executed by the parties. Except as modified specifically herein, all terms and conditions of the Agreement remain unchanged.

1) Article III Section 3.2, Section 3.5 and Section 3.6 are revised as follows. In addition, Section 3.7 and Section 3.8 are added to Article III:

Section 3.2 The Group shall provide Medical Mutual Services with copies of the Summary Plan Description and amendments thereto in a timely manner after adoption and execution of the same. The Group agrees that Benefit Books may be reviewed by Medical Mutual Services to ensure compliance with Medical Mutual Services' claims processing procedures.

If Medical Mutual does not prepare Benefit Books for Group, Group understands that Medical Mutual will not begin processing claims under this Agreement until Group has provided Medical Mutual with its most recent Summary Plan Description and/or benefit plan booklet, to ensure Medical Mutual can accurately administer claims for benefits, utilization review and medical policy under the Plan.

The Plan may be amended by the Group at its discretion. The Group shall give Medical Mutual Services written notice of any such amendment at least sixty (60) days before its effective date. It is the Group's obligation to notify Participants of any changes and the effective dates thereof and provide any required Summary of Material Modification. Any change in the nature of the services provided by Medical Mutual Services under this Agreement that would be caused by their amendment, must be approved in writing by Medical Mutual Services for the change in services to be included under this Agreement. Any such approved change shall also be a basis for Medical Mutual Services to request re-negotiation of the fee paid to Medical Mutual Services by the Group.

In the event the parties cannot agree on a new fee within thirty (30) days of the date Medical Mutual Services received written notice of the amendment, Medical Mutual Services shall have no obligation to provide the changed services, and the Group may withdraw its request for the amendment, or either party may terminate this Agreement upon thirty (30) days' written notice to the other party.

Section 3.5 The Group shall be financially liable for claims incurred by a Covered Person and paid by Medical Mutual Services prior to receipt from the Group of written or electronic notification of the termination of such Covered Person's enrollment in the Plan. The Group must provide Medical Mutual with written notice of any change in a person's eligibility under this Agreement in a prompt and timely manner and, in no circumstance, any later than thirty-one (31) days after the change occurs. 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. Medical Mutual will not recoup on behalf of the Group payments made to Providers in situations where rescission is not permitted by law. In the limited instances where retroactive termination is permitted by law, Medical Mutual Services will attempt to recoup payments made for former Participants who have been retroactively deleted from eligibility and credit the amounts recouped in the next billing cycle after the adjustment is processed.

Section 3.6 The Group shall furnish, in a prompt and timely manner, all information regarding the Plan and Covered Persons required by Medical Mutual Services to perform its obligations under this Agreement.

Section 3.7 The Group shall be responsible for reimbursing the Centers for Medicare & Medicaid Services (CMS) (or its designee) for any liability which may be imposed on the Plan under the Medicare Secondary Payer laws where the Plan paid claims on behalf of an individual on a secondary basis when in fact the Plan should have been primary to Medicare. The Group's liability shall remain in force and shall survive the termination of this Agreement. In no event will Medical Mutual Services assume responsibility for the Plan's liability under the Medicare Secondary Payer rules. In addition, the Group shall reimburse Medical Mutual Services for any costs or expenses incurred by Medical Mutual Services in determining such liability.

Section 3.8 Because a reduction in the Group's premium contribution can impact the Plan's grandfathered status, the Group must notify Medical Mutual Services 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.

2) Article IV is replaced in its entirety with the following:

ARTICLE IV
TERMINATION

Section 4.1 The initial term of the Agreement shall be for a period of twelve (12) months beginning on the Effective Date. Unless canceled or terminated earlier as provided for by this Agreement, the Agreement will renew for a further period of twelve (12) consecutive months and thereafter, from year to year. Renewal may be subject to new Administrative Fees and changes to Agreement terms. Except as provided below, Medical Mutual Services will provide 60 days' notice of its intent not to renew the Agreement.

The Group may cancel or terminate this Agreement without cause only upon thirty (30) days written notice to Medical Mutual Services. Medical Mutual Services may cancel or terminate this Agreement at any time with seven (7) days' notice if the Group fails to pay the amounts required by this Agreement. Medical Mutual Services' negotiation of any check sent or deposited into Medical Mutual Services' lockbox after the termination date does not constitute acceptance or reinstatement by Medical Mutual Services. Medical Mutual Services may also cancel or terminate this Agreement with thirty (30) days written notice in the event of fraud or misrepresentation by the Group.

Either party may terminate this Agreement in the event of a material breach of the terms of this Agreement by the other party, other than for a failure to pay as described in the immediately preceding paragraph. Such termination shall be effective thirty (30) days after written notice of the breach is delivered to the breaching party, unless the breach has been cured before the end of the thirty (30) day period.

If the Agreement is canceled or terminated, the Group must notify in writing all of its Participants of the cancellation or termination.

Section 4.2 Additionally, this Agreement shall automatically terminate as of the effective date of any legislative enactment which makes illegal the continuation of the Plan and/or this Agreement;

Section 4.3 If the Group fails to make any payment required by this Agreement when due, Medical Mutual Services may suspend processing of claims commencing on the day after such payment was due.

Section 4.4 The Group shall be liable for all Administrative Fees and claim payments due to Medical Mutual Services upon termination of this Agreement, as specifically described in the attached Addendum I.

Section 4.5 If this Agreement terminates, any claims not paid as of the Termination Effective Date shall be administered as described in Addendum I, Section 5.

4) The following provision is deleted from Article VIII, Section 8.11 in the Agreement is renumbered as Section 8.10.

Section 8.10 Exclusivity

Group agrees that the self funded health plan administered by Medical Mutual Services shall be the only group health plan (other than a flexible spending account) offered to Covered Persons during the term of this Agreement and Group shall not enter into an agreement with any other third party administrator or insurer to provide or administer health benefits on behalf of Covered Persons. Should Group violate this section of the Agreement, the early termination penalty provisions set forth in Section 6 of Addendum I shall apply as of the first date that Medical Mutual Services is not the exclusive administrator of health benefits provided to the Group.

5) Addendum I, ASO Weekly Invoicing, of the Agreement is replaced with the following Addendum.

ADDENDUM I
ASO WEEKLY INVOICING

This Addendum to the Agreement between **The County of Lorain #443492** (the "Group") and Medical Mutual Services, L. L. C. ("Medical Mutual Services") is an amendment to the Agreement and supersedes any prior invoicing Addendum and has been adopted pursuant to the section of the Agreement entitled "Amendments".

Section 1: Definitions

A. Agreement Period: The period beginning **January 1, 2013** through December 31, 2013.

B. Incurred Claim: A claim for Covered Services, as defined in the applicable Benefit Book(s), that has beginning service dates on or after the effective date of the Agreement and prior to the Termination Effective Date of the Agreement.

C. Adjudicated Claim: An Incurred Claim which has been processed and approved for payment but has not been released for payment by Medical Mutual Services.

D. Paid Claim: An Adjudicated Claim for which Medical Mutual Services has reimbursed the Provider or Participant on behalf of the Group. A claim is considered a Paid Claim as of the date shown on the check written by Medical Mutual Services. Claim Amounts will be paid in accordance with Medical Mutual Service's claims disbursement schedule.

E. Paid Claim Amount: The amount Medical Mutual Services pays to the Provider or the Participant for the individual claim, after the claim has been adjudicated and released for payment.

(i) For claims at hospitals and other institutions, the Paid Claim Amount shall not include adjustments or settlements due to maximum charge increase limitation violations, prompt payment discounts, or any settlement, incentive, allowance or adjustment that does not accrue to a specific claim at the time of adjudication.

(ii) For claims involving physicians or other professional providers, the Paid Claim Amount is not reduced by performance withholds.

(iii) For claims involving prescription drugs dispensed for use, the Paid Claim Amount does not include any formulary reimbursement savings, volume-based credits or refunds or discount guarantees.

(iv) In certain circumstances, Medical Mutual Services, through an affiliated company, may have an agreement or arrangement with a vendor which purchases services, supplies or products from Providers instead of Medical Mutual Services contracting directly with Providers themselves. Medical Mutual Services' agreement or arrangement with that vendor may not include the vendor's purchase price from the Provider, but may be based on some other financial arrangement such as a guaranteed discount.

The Paid Claim Amounts, in these circumstances, will be based on the network's re-pricing agreement with the vendor and not upon the vendor's actual purchase price with the Provider, subject to any further conditions or limitations set forth herein. Vendors include, but are not limited to, pharmacy providers, other managed care providers, home health providers and other provider networks.

(v) When the Covered Person receives services outside of the State of Ohio the claims for Covered Services will be processed whenever possible through a vendor relationship with another provider network with which Medical Mutual Services has contracted. The Paid Claim Amount for a claim submitted by an out of state provider will be based on the contractual arrangement the provider has with the network program. If the Plan's primary network does not have an arrangement with the provider, Medical Mutual Services will attempt to arrange for a discount through a secondary network. In such cases, any fees to obtain the discount will be included in the Paid Claim Amount. If there is no Agreement with a network provider, the Paid Claim Amount will be based on Net Covered Charges. The Group shall not be entitled to any further reduction or adjustment in the price of the claim other than what Medical Mutual Services receives from the network program.

F. Covered Charges: the charges for Covered Services, as defined in the applicable Benefits Book(s).

G. Net Covered Charges: Covered Charges less any deductibles, copayments, coinsurance or other patient liabilities and any amounts paid by other parties resulting from coordination of benefits, subrogation, workers' compensation and other party liability.

H. Administrative Fee: The monthly amount paid to Medical Mutual Services by the Group to cover administrative and other expenses per Participant per month. The Administrative Fee is specified in Exhibit A.

I. Provider Discount: Covered Charges minus the Paid Claim Amount.

J. Out of State Surcharges: The States of New York and Massachusetts have enacted legislation which imposes surcharges on certain health care costs incurred by Covered Persons receiving services in those states. Medical Mutual Services will pay the Out of State Surcharges directly to each state for the Group. The Group will be invoiced for actual Out of State Surcharges paid by Medical Mutual Services. Payment is due in accordance with the terms of the invoice. No additional Administrative Fee will be charged for this service. The same procedure will apply if other states pass similar legislation.

If any other tax (other than state or federal income taxes) or any other assessment or fee is assessed against the Plan, the claims administrator shall have no obligation to pay such tax, assessment or fee. The Group shall pay such tax, assessment or fee, once it determines it is subject to it. If Medical Mutual Services pays any such taxes, assessments or fees on behalf of the Group, the Group agrees to reimburse Medical Mutual Services for the full amount of such taxes, assessments or fees.

K. Termination Effective Date: 12:01 a.m. on the date the Agreement terminates for the group, any line(s) of business or any section(s) thereof, as specified pursuant to a written termination notice from one party to the other.

L. Access Fees: Amounts paid to Medical Mutual Services and/or the provider network(s) by the Group for use of the provider network(s).

Section 2: Invoicing

A. Weekly Invoices: Throughout the Agreement Period Medical Mutual Services shall invoice the Group each week for claims paid by Medical Mutual Services during the preceding week, and for Stop Loss credits as notified by the Stop Loss carrier. The Group will pay the invoiced amounts on the second business day following the date of the invoice. If payment of the invoice is not received when due, Medical Mutual Services will suspend processing of the group's claims and will not release future claim payments until payment is received from the Group.

B. Monthly Invoices: Throughout the Agreement Period Medical Mutual Services shall issue on a monthly basis an invoice for the Administrative Fee and for Stop Loss Premiums, on behalf of the Stop Loss Carrier. In addition, Medical Mutual Services shall issue a separate invoice on a monthly basis for the month's claims less amounts paid for weekly invoices for the month. Payment for each monthly invoice will be due to Medical Mutual Services on the first of each month or within ten (10) days of the date of the invoice, whichever is later. If the invoice is not paid when due, Medical Mutual Services will suspend payment of the group's claims and will not release future claim payments until payment is received from the Group.

C. Without waiving any other remedies Medical Mutual Services may have for non-payment or late payment by the Group of any amounts billed by Medical Mutual Services, including, but not limited to, Claims, Monthly Invoices and Out of State Surcharges, Medical Mutual Services reserves the right to change the Plan's claims invoicing method, described in 2A above, and will bill for claims adjudicated rather than claims paid. This means that Medical Mutual Services will invoice the Group for claims that are ready to be paid, but will not release those payments until funds for such claims are received from the Group. The change to an adjudicated invoicing method will commence immediately upon notification to the Group.

D. Medical Mutual Services, through an affiliated company, has Agreements with Providers, including hospitals. Some of these Agreements with Providers allow discounts, allowances, incentives, adjustments and settlements. These amounts are for the sole benefit of Medical Mutual Services and Medical Mutual Services will retain certain of the payments resulting therefrom as more fully set forth in Section 1E hereof. In any event, however, Paid Claim Amounts shall be calculated as provided herein, and deductibles, copayments, coinsurance and benefit accumulations shall be calculated as set forth in Addendum III or the Benefit Book(s).

E. The Group acknowledges and understands that the Paid Claim Amount may exceed the amount of Net Covered Charges for the Covered Services and that some of its payment responsibilities are nevertheless based on the Paid Claim Amounts and not upon the lesser of Net Covered Charges or the Paid Claim Amount.

Section 3: Management Reports

Medical Mutual Services shall prepare the following standard management reports for the Group:

Monthly Claims Detail
Annual Renewal Package
Quarterly Reporting Package

Reports or analyses not listed herein may be provided by Medical Mutual Services for a reasonable fee upon request of the Group.

Section 4: Changes to the Funding Arrangement

A. At least thirty (30) days prior to the renewal date of the Agreement, Medical Mutual Services will notify the Group of any changes in the Administrative Fees, Access Fees or other fee(s) and Agreement terms.

B. Medical Mutual Services reserves the right to adjust the fees, premiums and liability limits for the Agreement Period if the group's monthly enrollment changes, either in aggregate or for a specific line of business, by ten percent (10%) from the expected monthly enrollment specified in Exhibit A. Any adjustment in fees or liability limits will be effective as of the date of the change in enrollment.

Section 5: Termination

If the Agreement terminates for the group, line(s) of business or any section(s) thereof:

A. Medical Mutual Services will continue to process Incurred Claims where the incurred date(s) preceded the Termination Effective Date and which were received by Medical Mutual Services in accordance with the Group's applicable Benefit Book(s) and this Addendum I.

B. For the first twelve (12) weeks following the Termination Effective Date, Medical Mutual Services shall continue to invoice the Group weekly as described in Section 2A of this Addendum I.

C. After the first twelve weeks following the Termination Effective Date, Medical Mutual Services will invoice the Group Paid Claims monthly or less frequently, through the twelfth (12th) month after the Termination Effective Date. Payment of each invoice is due within ten (10) days of the date of the invoice.

D. Following the Termination Effective Date, Medical Mutual Services will continue to invoice the Group for Out of State Surcharges and Access Fees.

E. Medical Mutual Services will not process, pay or adjust any claims after the twelfth (12th) month following the Termination Effective Date and any claims submitted thereafter, if payable, in whole or in part, under the applicable Benefit Book(s) or Certificate(s) shall be the Group's payment responsibility solely and shall not be a liability of Medical Mutual Services.

F. Following the Termination Effective Date, if Medical Mutual Services receives any checks for payment of subrogation claims, Medical Mutual Services will forward those amounts to the Group, less any amounts related to the third party claim paid under applicable stop loss insurance for the Covered Person.

G. For three consecutive months following the Termination Effective Date, Medical Mutual Services will invoice the Group for the Administrative Fee per Participant times the greater of the number of Participants in effect in each applicable section at the Termination Effective Date or the average number of Participants in effect in each applicable section for the three (3) months immediately prior to the Termination Effective Date. The Group shall pay the invoiced amounts within ten (10) days of the date of each invoice.

H. If the Group does not pay any invoiced amount due on the date specified for payment, Medical Mutual Services may suspend payment of claims and any other responsibilities it may have after the Termination Effective Date until payment is received.

IN WITNESS WHEREOF, the Group and Medical Mutual Services have signed this Addendum I:

The County of Lorain
(the Group)

Signature

LORAIN COUNTY ADMINISTRATOR
Title

2-24-14
Date

Medical Mutual Services, L.L.C.
(Medical Mutual Services)

Signature

Richard A. Chiricosta
Chairman, President & CEO
Title

MAR 0 6 2014
Date

MEDICAL MUTUAL SERVICES, L.L.C.

EXHIBIT A
to
Addendum I
for
County of Lorain
Group Number: 443492
January 1, 2013 through December 31, 2013

Administrative Fee(s):*

Medical	$30.48
Commission	$4.00
TOTAL	$34.48

*Medical Administrative Fee(s) are guaranteed through December 31, 2015.

This rate guarantee does not include and does not apply to fees, taxes or other charges imposed on Medical Mutual by state or federal government laws, statutes or regulations. To the extent permitted by law, Medical Mutual Services will include such charges in the fees charged to the Plan Sponsor or may include them as separate line item on the Plan Sponsor's invoice.

Enrollment: 1,687

Guaranteed Minimum Provider Discount: The Guaranteed Minimum non-Medicare medical Provider Discount will be 54.0%. Medical Mutual will return five percent of the group's paid medical Administrative Fees, to a maximum penalty of 25 percent of the paid medical Administrative Fees for each one full point the actual Provider Discount falls below the guarantee. The Provider Discount may be negotiated annually at each renewal.

The Guaranteed Minimum Provider Discount assumes the Provider agreements and/or network composition agreements are not limited by or materially changed by any applicable laws or regulations. If a hospital freezes or reduces its charge master (Billed Charges) during an Agreement Period, Medical Mutual will assume the lesser of CPI-medical or 3.5% increase in charges for calculation of the discount guarantee, provided Medical Mutual can demonstrate that it would have met or exceeded the discount guarantee but for the hospital freezing or reducing its charge master. Amounts paid to Providers as part of a quality incentive program or fund are not included in the calculation of the guaranteed discount.

EXHIBIT B

COVERED ENTITIES UNDER THE COUNTY OF LORAIN

Medical Mutual has agreed to provide administrative services under this Agreement for the entities (listed below) who are members of the Lorain County benefit program for the period beginning January 1, 2013 through December 31, 2015. To the extent permitted by law, Medical Mutual agrees that it will not solicit, directly or indirectly, any of the groups covered under the Lorain County benefit program to purchase an insured or self-insured benefit plan from Medical Mutual or its affiliates during the time that this Agreement is in effect. However, under state and federal law until January 1, 2014, insurance policies for small employers with 2-50 employees are guaranteed issue. In 2014, guaranteed availability applies to all group health plans pursuant to Section 2702 of the Patient Protection and Affordable Care Act. Thus, if any small group covered under the Lorain County benefit program requests a fully insured quote from Medical Mutual prior to January 1, 2014, the company is obliged to provide one. For effective dates on and after January 1, 2014, Medical Mutual is obligated to provide a fully insured quote to any size group requesting one.

In addition, if any employer covered under the of Lorain County benefit program issues a formal RFP for insurance coverage or TPA services, Medical Mutual shall be permitted to respond to the RFP.

Amherst Township
Brownhelm Township
Camden Township
Carlisle Township
City of Avon
City of Sheffield Lake
Columbia Township
Eaton Township
Elyria Township
Grafton Township
Henrietta Township
Huntington Township
LaGrange Township
Lorain County Port Authority
NOACA
Penfield Township
Pittsfield Township
Sheffield Township
South Lorain County Ambulance District
Village of Grafton
Village of LaGrange
Village of Sheffield
Village of Wellington
Wellington Fire District
Wellington Township

RENEWAL
ADDENDUM I
ASO WEEKLY INVOICING

This Addendum to the Agreement between **The County of Lorain #443492** (the "Group") and Medical Mutual Services, L. L. C. ("Medical Mutual Services") is an amendment to the Agreement and supersedes any prior invoicing Addendum and has been adopted pursuant to the section of the Agreement entitled "Amendments".

Section 1: Definitions

A. Agreement Period: The period beginning **January 1, 2014** through December 31, 2014.

B. Incurred Claim: A claim for Covered Services, as defined in the applicable Benefit Book(s), that has beginning service dates on or after the effective date of the Agreement and prior to the Termination Effective Date of the Agreement.

C. Adjudicated Claim: An Incurred Claim which has been processed and approved for payment but has not been released for payment by Medical Mutual Services.

D. Paid Claim: An Adjudicated Claim for which Medical Mutual Services has reimbursed the Provider or Participant on behalf of the Group. A claim is considered a Paid Claim as of the date shown on the check written by Medical Mutual Services. Claim Amounts will be paid in accordance with Medical Mutual Service's claims disbursement schedule.

E. Paid Claim Amount: The amount Medical Mutual Services pays to the Provider or the Participant for the individual claim, after the claim has been adjudicated and released for payment.

(i) For claims at hospitals and other institutions, the Paid Claim Amount shall not include adjustments or settlements due to maximum charge increase limitation violations, prompt payment discounts, or any settlement, incentive, allowance or adjustment that does not accrue to a specific claim at the time of adjudication.

(ii) For claims involving physicians or other professional providers, the Paid Claim Amount is not reduced by performance withholds.

(iii) For claims involving prescription drugs dispensed for use, the Paid Claim Amount does not include any formulary reimbursement savings, volume-based credits or refunds or discount guarantees.

(iv) In certain circumstances, Medical Mutual Services, through an affiliated company, may have an agreement or arrangement with a vendor which purchases services, supplies or products from Providers instead of Medical Mutual Services contracting directly with Providers themselves. Medical Mutual Services' agreement or arrangement with that vendor may not include the vendor's purchase price from the Provider, but may be based on some other financial arrangement such as a guaranteed discount.

The Paid Claim Amounts, in these circumstances, will be based on the network's re-pricing agreement with the vendor and not upon the vendor's actual purchase price with the Provider, subject to any further conditions or limitations set forth herein. Vendors include, but are not limited to, pharmacy providers, other managed care providers, home health providers and other provider networks.

(v) When the Covered Person receives services outside of the State of Ohio the claims for Covered Services will be processed whenever possible through a vendor relationship with another provider network with which Medical Mutual Services has contracted. The Paid Claim Amount for a claim submitted by an out of state provider will be based on the contractual arrangement the provider has with the network program. If the Plan's primary network does not have an arrangement with the provider, Medical Mutual Services will attempt to arrange for a discount through a secondary network. In such cases, any fees to obtain the discount will be included in the Paid Claim Amount. If there is no Agreement with a network provider, the Paid Claim Amount will be based on Net Covered Charges. The Group shall not be entitled to any further reduction or adjustment in the price of the claim other than what Medical Mutual Services receives from the network program.

F. Covered Charges: the charges for Covered Services, as defined in the applicable Benefits Book(s).

G. Net Covered Charges: Covered Charges less any deductibles, copayments, coinsurance or other patient liabilities and any amounts paid by other parties resulting from coordination of benefits, subrogation, workers' compensation and other party liability.

H. Administrative Fee: The monthly amount paid to Medical Mutual Services by the Group to cover administrative and other expenses per Participant per month. The Administrative Fee is specified in Exhibit A.

I. Provider Discount: Covered Charges minus the Allowed Amount.

J. Allowed Amount: For PPO network Providers and contracting Providers, the Allowed Amount is the lesser of Medical Mutual Services' negotiated amount with the Provider or the Provider's billed charges. For non-contracting Providers, the Allowed Amount is Medical Mutual Services' non-contracting rate, which is the maximum amount allowed by Medical Mutual Services for Covered Services provided by a non-contracting Provider. The non-contracting rate is based on various factors, including, but not limited to, market rates for that service, negotiated amounts with PPO network Providers for that service, and Medicare reimbursement rates for that service.

K. Out of State Surcharges: The States of New York and Massachusetts have enacted legislation which imposes surcharges on certain health care costs incurred by Covered Persons receiving services in those states. Medical Mutual Services will pay the Out of State Surcharges directly to each state for the Group. The Group will be invoiced for actual Out of State Surcharges paid by Medical Mutual Services. Payment is due in accordance with the terms of the invoice. No additional Administrative Fee will be charged for this service. The same procedure will apply if other states pass similar legislation.

If any other tax (other than state or federal income taxes) or any other assessment or fee is assessed against the Plan, the claims administrator shall have no obligation to pay such tax, assessment or fee. The Group shall pay such tax, assessment or fee, once it determines it is subject to it. If Medical Mutual Services pays any such taxes, assessments or fees on behalf of the Group, the Group agrees to reimburse Medical Mutual Services for the full amount of such taxes, assessments or fees.

L. Termination Effective Date: 12:01 a.m. on the date the Agreement terminates for the group, any line(s) of business or any section(s) thereof, as specified pursuant to a written termination notice from one party to the other.

M. Access Fees: Amounts paid to Medical Mutual Services and/or the provider network(s) by the Group for use of the provider network(s).

Section 2: *Invoicing*

A. Weekly Invoices: Throughout the Agreement Period Medical Mutual Services shall invoice the Group each week for claims paid by Medical Mutual Services during the preceding week, and for Stop Loss credits as notified by the Stop Loss carrier. The Group will pay the invoiced amounts on the second business day following the date of the invoice. If payment of the invoice is not received when due, Medical Mutual Services will suspend processing of the group's claims and will not release future claim payments until payment is received from the Group.

B. Monthly Invoices: Throughout the Agreement Period Medical Mutual Services shall issue on a monthly basis an invoice for the Administrative Fee and for Stop Loss Premiums, on behalf of the Stop Loss Carrier. In addition, Medical Mutual Services shall issue a separate invoice on a monthly basis for the month's claims less amounts paid for weekly invoices for the month. Payment for each monthly invoice will be due to Medical Mutual Services on the first of each month or within ten (10) days of the date of the invoice, whichever is later. If the invoice is not paid when due, Medical Mutual Services will suspend payment of the group's claims and will not release future claim payments until payment is received from the Group.

C. Without waiving any other remedies Medical Mutual Services may have for non-payment or late payment by the Group of any amounts billed by Medical Mutual Services, including, but not limited to, Claims, Monthly Invoices and Out of State Surcharges, Medical Mutual Services reserves the right to change the Plan's claims invoicing method, described in 2A above, and will bill for claims adjudicated rather than claims paid. This means that Medical Mutual Services will invoice the Group for claims that are ready to be paid, but will not release those payments until funds for such claims are received from the Group. The change to an adjudicated invoicing method will commence immediately upon notification to the Group.

D. Medical Mutual Services, through an affiliated company, has Agreements with Providers, including hospitals. Some of these Agreements with Providers allow discounts, allowances, incentives, adjustments and settlements. These amounts are for the sole benefit of Medical Mutual Services and Medical Mutual Services will retain certain of the payments resulting therefrom as more fully set forth in Section 1E hereof. In any event, however, Paid Claim Amounts shall be calculated as provided herein, and deductibles, copayments, coinsurance and benefit accumulations shall be calculated as set forth in Addendum III or the Benefit Book(s).

E. The Group acknowledges and understands that the Paid Claim Amount may exceed the amount of Net Covered Charges for the Covered Services and that some of its payment responsibilities are nevertheless based on the Paid Claim Amounts and not upon the lesser of Net Covered Charges or the Paid Claim Amount.

Section 3: Management Reports

Medical Mutual Services shall prepare the following standard management reports for the Group:

Monthly Claims Detail
Annual Renewal Package
Quarterly Reporting Package

Reports or analyses not listed herein may be provided by Medical Mutual Services for a reasonable fee upon request of the Group.

Section 4: Changes to the Funding Arrangement

A. At least thirty (30) days prior to the renewal date of the Agreement, Medical Mutual Services will notify the Group of any changes in the Administrative Fees, Access Fees or other fee(s) and Agreement terms.

B. Medical Mutual Services reserves the right to adjust the fees, premiums and liability limits for the Agreement Period if the group's monthly enrollment changes, either in aggregate or for a specific line of business, by ten percent (10%) from the expected monthly enrollment specified in Exhibit A. Any adjustment in fees or liability limits will be effective as of the date of the change in enrollment.

Section 5: Termination

If the Agreement terminates for the group, line(s) of business or any section(s) thereof:

A. Medical Mutual Services will continue to process Incurred Claims where the incurred date(s) preceded the Termination Effective Date and which were received by Medical Mutual Services in accordance with the Group's applicable Benefit Book(s) and this Addendum I.

B. For the first twelve (12) weeks following the Termination Effective Date, Medical Mutual Services shall continue to invoice the Group weekly as described in Section 2A of this Addendum I.

C. After the first twelve weeks following the Termination Effective Date, Medical Mutual Services will invoice the Group Paid Claims monthly or less frequently, through the twelfth (12th) month after the Termination Effective Date. Payment of each invoice is due within ten (10) days of the date of the invoice.

D. Following the Termination Effective Date, Medical Mutual Services will continue to invoice the Group for Out of State Surcharges and Access Fees.

E. Medical Mutual Services will not process, pay or adjust any claims after the twelfth (12th) month following the Termination Effective Date and any claims submitted thereafter, if payable, in whole or in part, under the applicable Benefit Book(s) or Certificate(s) shall be the Group's payment responsibility solely and shall not be a liability of Medical Mutual Services.

F. Following the Termination Effective Date, if Medical Mutual Services receives any checks for payment of subrogation claims, Medical Mutual Services will forward those amounts to the Group, less any amounts related to the third party claim paid under applicable stop loss insurance for the Covered Person.

G. For three consecutive months following the Termination Effective Date, Medical Mutual Services will invoice the Group for the Administrative Fee per Participant times the greater of the number of Participants in effect in each applicable section at the Termination Effective Date or the average number of Participants in effect in each applicable section for the three (3) months immediately prior to the Termination Effective Date. The Group shall pay the invoiced amounts within ten (10) days of the date of each invoice.

H. If the Group does not pay any invoiced amount due on the date specified for payment, Medical Mutual Services may suspend payment of claims and any other responsibilities it may have after the Termination Effective Date until payment is received.

IN WITNESS WHEREOF, the Group and Medical Mutual Services have signed this Addendum I:

The County of Lorain
(the Group)

Signature

LORAIN COUNTY ADMINISTRATOR
Title

2-24-14
Date

Medical Mutual Services, L.L.C.
(Medical Mutual Services)

Signature

Richard A. Chiricosta
Chairman, President & CEO
Title

MAR 0 6 2014
Date

MEDICAL MUTUAL SERVICES, L.L.C.

EXHIBIT A
to
Addendum I
for
County of Lorain #443492
January 1, 2014 through December 31, 2014

Administrative Fee(s):*

Medical	$30.48
Commission	$4.00
TOTAL	$34.48

*Medical Administrative Fee(s) are guaranteed through December 31, 2015.

This rate guarantee does not include and does not apply to fees, taxes or other charges imposed on Medical Mutual by state or federal government laws, statutes or regulations. To the extent permitted by law, Medical Mutual Services will include such charges in the fees charged to the Plan Sponsor or may include them as separate line item on the Plan Sponsor's invoice.

Prisoners Section 003 Medical Administrative Fee: 25% of the Provider Discount

Enrollment: 1,632

Guaranteed Minimum Provider Discount: Medical Mutual Services will provide the Group a Provider Discount guarantee of at least 54.0% of Covered Charges for Ohio, in-Network, medical services for which coverage administered by Medical Mutual Services is primary. If the actual Provider Discount achieved by Medical Mutual Services for the 2014 Agreement Period is less than the Provider Discount guarantee, Medical Mutual Services will reimburse the Group for 5.0% of the non-Medicare Medical Administrative Fees for each 1% the Provider Discount is less than the 54% guarantee, with a maximum reimbursement of 25% of the non-Medicare Medical Administrative Fees. See table below. The Provider Discount guarantee measurement will be based on claims paid from 1/1/2014 through 12/31/2014.

	Provider Discount Achieved	*Administrative Fee Reimbursement*
	>= 54%	0.00%
	>= 53%, < 54%	5.00%
	>= 52%, < 53%	10.00%
	>= 51%, < 52%	15.00%
	>= 50%, < 51%	20.00%
	>= 49%, < 50%	25.00%

Administrative fees include non-Medicare Medical Administration Fees only. This discount guarantee is subject to change if enrollment varies by 10% or more and/or the geographic distribution of members changes significantly.

The Guaranteed Minimum Provider Discount assumes the Provider agreements and/or network composition agreements are not limited by or materially changed by any applicable laws or regulations. If a hospital freezes or reduces its charge master (Billed Charges) during an Agreement Period, Medical Mutual will assume the lesser of CPI-medical or 3.5% increase in charges for calculation of the discount guarantee, provided Medical Mutual can demonstrate that it would have met or exceeded the discount guarantee but for the hospital freezing or reducing its charge master. Amounts paid to Providers as part of a quality incentive program or fund are not included in the calculation of the guaranteed discount.

EXHIBIT B

COVERED ENTITIES UNDER THE COUNTY OF LORAIN

Medical Mutual has agreed to provide administrative services under this Agreement for the entities (listed below) who are members of the Lorain County benefit program for the period beginning January 1, 2013 through December 31, 2015. To the extent permitted by law, Medical Mutual agrees that it will not solicit, directly or indirectly, any of the groups covered under the Lorain County benefit program to purchase an insured or self-insured benefit plan from Medical Mutual or its affiliates during the time that this Agreement is in effect. However, under state and federal law until January 1, 2014, insurance policies for small employers with 2-50 employees are guaranteed issue. In 2014, guaranteed availability applies to all group health plans pursuant to Section 2702 of the Patient Protection and Affordable Care Act. Thus, if any small group covered under the Lorain County benefit program requests a fully insured quote from Medical Mutual prior to January 1, 2014, the company is obliged to provide one. For effective dates on and after January 1, 2014, Medical Mutual is obligated to provide a fully insured quote to any size group requesting one.

In addition, if any employer covered under the of Lorain County benefit program issues a formal RFP for insurance coverage or TPA services, Medical Mutual shall be permitted to respond to the RFP.

Amherst Township
Brownheim Township
Camden Township
Carlisle Township
City of Avon
City of Sheffield Lake
Columbia Township
Eaton Township
Elyria Township
Grafton Township
Henrietta Township
Huntington Township
LaGrange Township
Lorain County Port Authority
NOACA
Penfield Township
Pittsfield Township
Sheffield Township
South Lorain County Ambulance District
Village of Grafton
Village of LaGrange
Village of Sheffield
Village of Wellington
Wellington Fire District
Wellington Township

Exhibit 2

AMENDMENT

to the Administrative Services Agreement for
City of Elyria

This Amendment modifies the Administrative Services Agreement (the Agreement), dated February 1, 2010, entered into between **City of Elyria #722263** (the "Group") and Medical Mutual Services, L.L.C. (Medical Mutual Services).

The Effective Date of this Amendment is **February 1, 2013** at 12:01 a.m., regardless of the date executed by the parties. Except as modified specifically herein, all terms and conditions of the Agreement remain unchanged.

1) Article III Section 3.2, Section 3.5 and Section 3.6 are revised as follows. In addition, Section 3.7 and Section 3.8 are added to Article III:

Section 3.2 The Group shall provide Medical Mutual Services with copies of the Summary Plan Description and amendments thereto in a timely manner after adoption and execution of the same. The Group agrees that Benefit Books may be reviewed by Medical Mutual Services to ensure compliance with Medical Mutual Services' claims processing procedures.

If Medical Mutual does not prepare Benefit Books for Group, Group understands that Medical Mutual will not begin processing claims under this Agreement until Group has provided Medical Mutual with its most recent Summary Plan Description and/or benefit plan booklet, to ensure Medical Mutual can accurately administer claims for benefits, utilization review and medical policy under the Plan.

The Plan may be amended by the Group at its discretion. The Group shall give Medical Mutual Services written notice of any such amendment at least sixty (60) days before its effective date. It is the Group's obligation to notify Participants of any changes and the effective dates thereof and provide any required Summary of Material Modification. Any change in the nature of the services provided by Medical Mutual Services under this Agreement that would be caused by their amendment, must be approved in writing by Medical Mutual Services for the change in services to be included under this Agreement. Any such approved change shall also be a basis for Medical Mutual Services to request re-negotiation of the fee paid to Medical Mutual Services by the Group.

In the event the parties cannot agree on a new fee within thirty (30) days of the date Medical Mutual Services received written notice of the amendment, Medical Mutual Services shall have no obligation to provide the changed services and Medical Mutual Services may terminate this Agreement upon thirty (30) days prior written notice to the Group.

Section 3.5 The Group shall be financially liable for claims incurred by a Covered Person and paid by Medical Mutual Services prior to receipt from the Group of written or electronic notification of the termination of such Covered Person's enrollment in the Plan. The Group must provide Medical Mutual with written notice of any change in a person's eligibility under this Agreement in a prompt and timely manner and, in no circumstance, any later than thirty-one (31) days after the change occurs. 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. Medical Mutual will not recoup on behalf of the Group payments made to Providers in situations where rescission is not permitted by law. In the limited instances where retroactive termination is permitted by law, Medical Mutual Services will attempt to recoup payments made for former Participants who have been retroactively deleted from eligibility and credit the amounts recouped in the next billing cycle after the adjustment is processed.

Section 3.6 The Group shall furnish, in a prompt and timely manner, all information regarding the Plan and Covered Persons required by Medical Mutual Services to perform its obligations under this Agreement.

Section 3.7 The Group shall be responsible for reimbursing the Centers for Medicare & Medicaid Services (CMS) (or its designee) for any liability which may be imposed on the Plan under the Medicare Secondary Payer laws where the Plan paid claims on behalf of an individual on a secondary basis when in fact the Plan should have been primary to Medicare. The Group's liability shall remain in force and shall survive the termination of this Agreement. In no event will Medical Mutual Services assume responsibility for the Plan's liability under the Medicare Secondary Payer rules. In addition, the Group shall reimburse Medical Mutual Services for any costs or expenses incurred by Medical Mutual Services in determining such liability.

Section 3.8 Because a reduction in the Group's premium contribution can impact the Plan's grandfathered status, the Group must notify Medical Mutual Services 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.

2) Article IV is replaced in its entirety with the following:

ARTICLE IV
TERMINATION

Section 4.1 The initial term of the Agreement shall be for a period of twelve (12) months beginning on the Effective Date. Unless canceled or terminated earlier as provided for by this Agreement, the Agreement will renew for a further period of twelve (12) consecutive months and thereafter, from year to year. Renewal may be subject to new Administrative Fees and changes to Agreement terms. Except as provided below, Medical Mutual Services will provide 60 days' notice of its intent not to renew the Agreement.

The Group may cancel or terminate this Agreement without cause only upon thirty (30) days written notice to Medical Mutual Services. Medical Mutual Services may cancel or terminate this Agreement at any time without notice if the Group fails to pay the amounts required by this Agreement. Medical Mutual Services' negotiation of any check sent or deposited into Medical Mutual Services' lockbox after the termination date does not constitute acceptance or reinstatement by Medical Mutual Services. Medical Mutual Services may also cancel or terminate this Agreement with thirty (30) days written notice in the event of fraud or misrepresentation by the Group.

Either party may terminate this Agreement in the event of a material breach of the terms of this Agreement by the other party, other than for a failure to pay as described in the immediately preceding paragraph. Such termination shall be effective thirty (30) days after written notice of the breach is delivered to the breaching party, unless the breach has been cured before the end of the thirty (30) day period.

If the Agreement is canceled or terminated, the Group must notify in writing all of its Participants of the cancellation or termination.

Section 4.2 Additionally, this Agreement shall automatically terminate as of the effective date of any legislative enactment which makes illegal the continuation of the Plan and/or this Agreement;

Section 4.3 If the Group fails to make any payment required by this Agreement when due, Medical Mutual Services may suspend processing of claims commencing on the day after such payment was due.

Section 4.4 The Group shall be liable for all Administrative Fees and claim payments due to Medical Mutual Services upon termination of this Agreement, as specifically described in the attached Addendum I.

Section 4.5 If this Agreement terminates, any claims not paid as of the Termination Effective Date shall be administered as described in Addendum I, Section 5.

4) The following provision is deleted from Article VIII. Section 8.11 in the Agreement is renumbered as Section 8.10.

Section 8.10 Exclusivity

Group agrees that the self funded health plan administered by Medical Mutual Services shall be the only group health plan (other than a flexible spending account) offered to Covered Persons during the term of this Agreement and Group shall not enter into an agreement with any other third party administrator or insurer to provide or administer health benefits on behalf of Covered Persons. Should Group violate this section of the Agreement, the early termination penalty provisions set forth in Section 6 of Addendum I shall apply as of the first date that Medical Mutual Services is not the exclusive administrator of health benefits provided to the Group.

5) Addendum I, ASO Weekly Invoicing, of the Agreement is replaced with the following Addendum:

ADDENDUM I
ASO WEEKLY INVOICING

This Addendum to the Agreement between **City of Elyria #722263** (the "Group") and Medical Mutual Services, L. L. C. ("Medical Mutual Services") is an amendment to the Agreement and supersedes any prior invoicing Addendum and has been adopted pursuant to the section of the Agreement entitled "Amendments".

Section 1: Definitions

A. Agreement Period: The period beginning **February 1, 2013** through January 31, 2014.

B. Incurred Claim: A claim for Covered Services, as defined in the applicable Benefit Book(s), that has beginning service dates on or after the effective date of the Agreement and prior to the Termination Effective Date of the Agreement.

C. Adjudicated Claim: An Incurred Claim which has been processed and approved for payment but has not been released for payment by Medical Mutual Services.

D. Paid Claim: An Adjudicated Claim for which Medical Mutual Services has reimbursed the Provider or Participant on behalf of the Group. A claim is considered a Paid Claim as of the date shown on the check written by Medical Mutual Services. Claim Amounts will be paid in accordance with Medical Mutual Service's claims disbursement schedule.

E. Paid Claim Amount: The amount Medical Mutual Services pays to the Provider or the Participant for the individual claim, after the claim has been adjudicated and released for payment.

(i) For claims at hospitals and other institutions, the Paid Claim Amount shall not include adjustments or settlements due to maximum charge increase limitation violations, prompt payment discounts, or any settlement, incentive, allowance or adjustment that does not accrue to a specific claim at the time of adjudication.

(ii) For claims involving physicians or other professional providers, the Paid Claim Amount is not reduced by performance withholds.

(iii) For claims involving prescription drugs dispensed for use, the Paid Claim Amount does not include any formulary reimbursement savings, volume-based credits or refunds or discount guarantees.

(iv) In certain circumstances, Medical Mutual Services, through an affiliated company, may have an agreement or arrangement with a vendor which purchases services, supplies or products from Providers instead of Medical Mutual Services contracting directly with Providers themselves. Medical Mutual Services' agreement or arrangement with that vendor may not include the vendor's purchase price from the Provider, but may be based on some other financial arrangement such as a guaranteed discount.

The Paid Claim Amounts, in these circumstances, will be based on the network's re-pricing agreement with the vendor and not upon the vendor's actual purchase price with the Provider, subject to any further conditions or limitations set forth herein. Vendors include, but are not limited to, pharmacy providers, other managed care providers, home health providers and other provider networks.

(v) When the Covered Person receives services outside of the State of Ohio the claims for Covered Services will be processed whenever possible through a vendor relationship with another provider network with which Medical Mutual Services has contracted. The Paid Claim Amount for a claim submitted by an out of state provider will be based on the contractual arrangement the provider has with the network program. If the Plan's primary network does not have an arrangement with the provider, Medical Mutual Services will attempt to arrange for a discount through a secondary network. In such cases, any fees to obtain the discount will be included in the Paid Claim Amount. If there is no Agreement with a network provider, the Paid Claim Amount will be based on Net Covered Charges. The Group shall not be entitled to any further reduction or adjustment in the price of the claim other than what Medical Mutual Services receives from the network program.

F. Covered Charges: the charges for Covered Services, as defined in the applicable Benefits Book(s).

G. Net Covered Charges: Covered Charges less any deductibles, copayments, coinsurance or other patient liabilities and any amounts paid by other parties resulting from coordination of benefits, subrogation, workers' compensation and other party liability.

H. Administrative Fee: The monthly amount paid to Medical Mutual Services by the Group to cover administrative and other expenses per Participant per month. The Administrative Fee is specified in Exhibit A.

I. Provider Discount: Covered Charges minus the Paid Claim Amount.

J. Out of State Surcharges: The States of New York, Massachusetts and Michigan have enacted legislation which imposes surcharges on certain health care costs incurred by Covered Persons receiving services in those states. Medical Mutual Services will pay the Out of State Surcharges directly to each state for the Group. The Group will be invoiced for actual Out of State Surcharges paid by Medical Mutual Services. Payment is due in accordance with the terms of the invoice. No additional Administrative Fee will be charged for this service. The same procedure will apply if other states pass similar legislation.

If any other tax (other than state or federal income taxes) or any other assessment or fee is assessed against the Plan, the claims administrator shall have no obligation to pay such tax, assessment or fee. The Group shall pay such tax, assessment or fee, once it determines it is subject to it. If Medical Mutual Services pays any such taxes, assessments or fees on behalf of the Group, the Group agrees to reimburse Medical Mutual Services for the full amount of such taxes, assessments or fees.

K. Termination Effective Date: 12:01 a.m. on the date the Agreement terminates for the group, any line(s) of business or any section(s) thereof, as specified pursuant to a written termination notice from one party to the other.

L. Access Fees: Amounts paid to Medical Mutual Services and/or the provider network(s) by the Group for use of the provider network(s).

Section 2: Invoicing

A. Weekly Invoices: Throughout the Agreement Period Medical Mutual Services shall invoice the Group each week for claims paid by Medical Mutual Services during the preceding week, and for Stop Loss credits as notified by the Stop Loss carrier. The Group will pay the invoiced amounts on the second business day following the date of the invoice. If payment of the invoice is not received when due, Medical Mutual Services will suspend processing of the group's claims and will not release future claim payments until payment is received from the Group.

B. Monthly Invoices: Throughout the Agreement Period Medical Mutual Services shall issue on a monthly basis an invoice for the Administrative Fee and for Stop Loss Premiums, on behalf of the Stop Loss Carrier. In addition, Medical Mutual Services shall issue a separate invoice on a monthly basis for the month's claims less amounts paid for weekly invoices for the month. Payment for each monthly invoice will be due to Medical Mutual Services on the first of each month or within ten (10) days of the date of the invoice, whichever is later. If the invoice is not paid when due, Medical Mutual Services will suspend payment of the group's claims and will not release future claim payments until payment is received from the Group.

C. Without waiving any other remedies Medical Mutual Services may have for non-payment or late payment by the Group of any amounts billed by Medical Mutual Services, including, but not limited to, Claims, Monthly Invoices and Out of State Surcharges, Medical Mutual Services reserves the right to change the Plan's claims invoicing method, described in 2A above, and will bill for claims adjudicated rather than claims paid. This means that Medical Mutual Services will invoice the Group for claims that are ready to be paid, but will not release those payments until funds for such claims are received from the Group. The change to an adjudicated invoicing method will commence immediately upon notification to the Group.

D. Medical Mutual Services, through an affiliated company, has Agreements with Providers, including hospitals. Some of these Agreements with Providers allow discounts, allowances, incentives, adjustments and settlements. These amounts are for the sole benefit of Medical Mutual Services and Medical Mutual Services will retain certain of the payments resulting therefrom as more fully set forth in Section 1E hereof. In any event, however, Paid Claim Amounts shall be calculated as provided herein, and deductibles, copayments, coinsurance and benefit accumulations shall be calculated as set forth in Addendum III or the Benefit Book(s).

E. The Group acknowledges and understands that the Paid Claim Amount may exceed the amount of Net Covered Charges for the Covered Services and that some of its payment responsibilities are nevertheless based on the Paid Claim Amounts and not upon the lesser of Net Covered Charges or the Paid Claim Amount.

Section 3: Management Reports

Medical Mutual Services shall prepare the following standard management reports for the Group:

Monthly Claims Detail
Annual Renewal Package
Quarterly Reporting Package

Reports or analyses not listed herein may be provided by Medical Mutual Services for a reasonable fee upon request of the Group.

Section 4: Changes to the Funding Arrangement

A. At least thirty (30) days prior to the renewal date of the Agreement, Medical Mutual Services will notify the Group of any changes in the Administrative Fees, Access Fees or other fee(s) and Agreement terms.

B. Medical Mutual Services reserves the right to adjust the fees, premiums and liability limits for the Agreement Period if the group's monthly enrollment changes, either in aggregate or for a specific line of business, by ten percent (10%) from the expected monthly enrollment specified in Exhibit A. Any adjustment in fees or liability limits will be effective as of the date of the change in enrollment.

Section 5: Termination

If the Agreement terminates for the group, line(s) of business or any section(s) thereof:

A. Medical Mutual Services will continue to process Incurred Claims where the incurred date(s) preceded the Termination Effective Date and which were received by Medical Mutual Services in accordance with the Group's applicable Benefit Book(s) and this Addendum I.

B. For the first twelve (12) weeks following the Termination Effective Date, Medical Mutual Services shall continue to invoice the Group weekly as described in Section 2A of this Addendum I.

C. After the first twelve weeks following the Termination Effective Date, Medical Mutual Services will invoice the Group Paid Claims monthly or less frequently, through the twelfth (12th) month after the Termination Effective Date. Payment of each invoice is due within ten (10) days of the date of the invoice.

D. Following the Termination Effective Date, Medical Mutual Services will continue to invoice the Group for Out of State Surcharges and Access Fees.

E. Medical Mutual Services will not process, pay or adjust any claims after the twelfth (12th) month following the Termination Effective Date and any claims submitted thereafter, if payable, in whole or in part, under the applicable Benefit Book(s) or Certificate(s) shall be the Group's payment responsibility solely and shall not be a liability of Medical Mutual Services.

F. Following the Termination Effective Date, if Medical Mutual Services receives any checks for payment of subrogation claims, Medical Mutual Services will forward those amounts to the Group, less any amounts related to the third party claim paid under applicable stop loss insurance for the Covered Person.

G. For three consecutive months following the Termination Effective Date, Medical Mutual Services will invoice the Group for the Administrative Fee per Participant times the greater of the number of Participants in effect in each applicable section at the Termination Effective Date or the average number of Participants in effect in each applicable section for the three (3) months immediately prior to the Termination Effective Date. The Group shall pay the invoiced amounts within ten (10) days of the date of each invoice.

H. If the Group does not pay any invoiced amount due on the date specified for payment, Medical Mutual Services may suspend payment of claims and any other responsibilities it may have after the Termination Effective Date until payment is received.

IN WITNESS WHEREOF, the Group and Medical Mutual Services have signed this Addendum I:

City of Elyria
(the Group)

Richard D. Jackson
Signature

ASST. SAFETY SVC. DIR.
Title

5/30/13
Date

Medical Mutual Services, L.L.C.
(Medical Mutual Services)

Signature

Patrick J. Dugan
Corporate Secretary
Title

JUL 11 2013
Date

MEDICAL MUTUAL SERVICES, L.L.C.

EXHIBIT A
to
Addendum I
for
City of Elyria
Number 722263
February 1, 2013 through January 31, 2014

Administrative Fee:

Medical	$47.22*
Drug	$ 1.50
Dental	$ 3.39

**Includes $10.00 commission*

The medical Administrative Fee for section 002 (Prisoners) will be 20% of the Provider Discount for claims in section 002.

Enrollment: 447

RENEWAL
ADDENDUM I
ASO WEEKLY INVOICING

This Addendum to the Agreement between **City of Elyria #722263** (the "Group") and Medical Mutual Services, L. L. C. ("Medical Mutual Services") is an amendment to the Agreement and supersedes any prior invoicing Addendum and has been adopted pursuant to the section of the Agreement entitled "Amendments".

Section 1: Definitions

A. Agreement Period: The period beginning **February 1, 2014** through December 31, 2014.

B. Incurred Claim: A claim for Covered Services, as defined in the applicable Benefit Book(s), that has beginning service dates on or after the effective date of the Agreement and prior to the Termination Effective Date of the Agreement.

C. Adjudicated Claim: An Incurred Claim which has been processed and approved for payment but has not been released for payment by Medical Mutual Services.

D. Paid Claim: An Adjudicated Claim for which Medical Mutual Services has reimbursed the Provider or Participant on behalf of the Group. A claim is considered a Paid Claim as of the date shown on the check written by Medical Mutual Services. Claim Amounts will be paid in accordance with Medical Mutual Service's claims disbursement schedule.

E. Paid Claim Amount: The amount Medical Mutual Services pays to the Provider or the Participant for the individual claim, after the claim has been adjudicated and released for payment.

(i) For claims at hospitals and other institutions, the Paid Claim Amount shall not include adjustments or settlements due to maximum charge increase limitation violations, prompt payment discounts, or any settlement, incentive, allowance or adjustment that does not accrue to a specific claim at the time of adjudication.

(ii) For claims involving physicians or other professional providers, the Paid Claim Amount is not reduced by performance withholds.

(iii) For claims involving prescription drugs dispensed for use, the Paid Claim Amount does not include any formulary reimbursement savings, volume-based credits or refunds or discount guarantees.

(iv) In certain circumstances, Medical Mutual Services, through an affiliated company, may have an agreement or arrangement with a vendor which purchases services, supplies or products from Providers instead of Medical Mutual Services contracting directly with Providers themselves. Medical Mutual Services' agreement or arrangement with that vendor may not include the vendor's purchase price from the Provider, but may be based on some other financial arrangement such as a guaranteed discount.

The Paid Claim Amounts, in these circumstances, will be based on the network's re-pricing agreement with the vendor and not upon the vendor's actual purchase price with the Provider, subject to any further conditions or limitations set forth herein. Vendors include, but are not limited to, pharmacy providers, other managed care providers, home health providers and other provider networks.

(v) When the Covered Person receives services outside of the State of Ohio the claims for Covered Services will be processed whenever possible through a vendor relationship with another provider network with which Medical Mutual Services has contracted. The Paid Claim Amount for a claim submitted by an out of state provider will be based on the contractual arrangement the provider has with the network program. If the Plan's primary network does not have an arrangement with the provider, Medical Mutual Services will attempt to arrange for a discount through a secondary network. In such cases, any fees to obtain the discount will be included in the Paid Claim Amount. If there is no Agreement with a network provider, the Paid Claim Amount will be based on Net Covered Charges. The Group shall not be entitled to any further reduction or adjustment in the price of the claim other than what Medical Mutual Services receives from the network program.

F. Covered Charges: the charges for Covered Services, as defined in the applicable Benefits Book(s).

G. Net Covered Charges: Covered Charges less any deductibles, copayments, coinsurance or other patient liabilities and any amounts paid by other parties resulting from coordination of benefits, subrogation, workers' compensation and other party liability.

H. Administrative Fee: The monthly amount paid to Medical Mutual Services by the Group to cover administrative and other expenses per Participant per month. The Administrative Fee is specified in Exhibit A.

I. Provider Discount: Covered Charges minus the Allowed Amount.

J. Allowed Amount: For PPO network Providers and contracting Providers, the Allowed Amount is the lesser of Medical Mutual Services' negotiated amount with the Provider or the Provider's billed charges. For non-contracting Providers, the Allowed Amount is Medical Mutual Services' non-contracting rate, which is the maximum amount allowed by Medical Mutual Services for Covered Services provided by a non-contracting Provider. The non-contracting rate is based on various factors, including, but not limited to, market rates for that service, negotiated amounts with PPO network Providers for that service, and Medicare reimbursement rates for that service.

K. Out of State Surcharges: The States of New York, Massachusetts and Michigan have enacted legislation which imposes surcharges on certain health care costs incurred by Covered Persons receiving services in those states. Medical Mutual Services will pay the Out of State Surcharges directly to each state for the Group. The Group will be invoiced for actual Out of State Surcharges paid by Medical Mutual Services. Payment is due in accordance with the terms of the invoice. No additional Administrative Fee will be charged for this service. The same procedure will apply if other states pass similar legislation.

If any other tax (other than state or federal income taxes) or any other assessment or fee is assessed against the Plan, the claims administrator shall have no obligation to pay such tax, assessment or fee. The Group shall pay such tax, assessment or fee, once it determines it is subject to it. If Medical Mutual Services pays any such taxes, assessments or fees on behalf of the Group, the Group agrees to reimburse Medical Mutual Services for the full amount of such taxes, assessments or fees.

L. Termination Effective Date: 12:01 a.m. on the date the Agreement terminates for the group, any line(s) of business or any section(s) thereof, as specified pursuant to a written termination notice from one party to the other.

M. Access Fees: Amounts paid to Medical Mutual Services and/or the provider network(s) by the Group for use of the provider network(s).

Section 2: Invoicing

A. Weekly Invoices: Throughout the Agreement Period Medical Mutual Services shall invoice the Group each week for claims paid by Medical Mutual Services during the preceding week, and for Stop Loss credits as notified by the Stop Loss carrier. The Group will pay the invoiced amounts on the second business day following the date of the invoice. If payment of the invoice is not received when due, Medical Mutual Services will suspend processing of the group's claims and will not release future claim payments until payment is received from the Group.

B. Monthly Invoices: Throughout the Agreement Period Medical Mutual Services shall issue on a monthly basis an invoice for the Administrative Fee and for Stop Loss Premiums, on behalf of the Stop Loss Carrier. In addition, Medical Mutual Services shall issue a separate invoice on a monthly basis for the month's claims less amounts paid for weekly invoices for the month. Payment for each monthly invoice will be due to Medical Mutual Services on the first of each month or within ten (10) days of the date of the invoice, whichever is later. If the invoice is not paid when due, Medical Mutual Services will suspend payment of the group's claims and will not release future claim payments until payment is received from the Group.

C. Without waiving any other remedies Medical Mutual Services may have for non-payment or late payment by the Group of any amounts billed by Medical Mutual Services, including, but not limited to, Claims, Monthly Invoices and Out of State Surcharges, Medical Mutual Services reserves the right to change the Plan's claims invoicing method, described in 2A above, and will bill for claims adjudicated rather than claims paid. This means that Medical Mutual Services will invoice the Group for claims that are ready to be paid, but will not release those payments until funds for such claims are received from the Group. The change to an adjudicated invoicing method will commence immediately upon notification to the Group.

D. Medical Mutual Services, through an affiliated company, has Agreements with Providers, including hospitals. Some of these Agreements with Providers allow discounts, allowances, incentives, adjustments and settlements. These amounts are for the sole benefit of Medical Mutual Services and Medical Mutual Services will retain certain of the payments resulting therefrom as more fully set forth in Section 1E hereof. In any event, however, Paid Claim Amounts shall be calculated as provided herein, and deductibles, copayments, coinsurance and benefit accumulations shall be calculated as set forth in Addendum III or the Benefit Book(s).

E. The Group acknowledges and understands that the Paid Claim Amount may exceed the amount of Net Covered Charges for the Covered Services and that some of its payment responsibilities are nevertheless based on the Paid Claim Amounts and not upon the lesser of Net Covered Charges or the Paid Claim Amount.

Section 3: Management Reports

Medical Mutual Services shall prepare the following standard management reports for the Group:

Monthly Claims Detail
Annual Renewal Package
Quarterly Reporting Package

Reports or analyses not listed herein may be provided by Medical Mutual Services for a reasonable fee upon request of the Group.

Section 4: Changes to the Funding Arrangement

A. At least thirty (30) days prior to the renewal date of the Agreement, Medical Mutual Services will notify the Group of any changes in the Administrative Fees, Access Fees or other fee(s) and Agreement terms.

B. Medical Mutual Services reserves the right to adjust the fees, premiums and liability limits for the Agreement Period if the group's monthly enrollment changes, either in aggregate or for a specific line of business, by ten percent (10%) from the expected monthly enrollment specified in Exhibit A. Any adjustment in fees or liability limits will be effective as of the date of the change in enrollment.

Section 5: Termination

If the Agreement terminates for the group, line(s) of business or any section(s) thereof:

A. Medical Mutual Services will continue to process Incurred Claims where the incurred date(s) preceded the Termination Effective Date and which were received by Medical Mutual Services in accordance with the Group's applicable Benefit Book(s) and this Addendum I.

B. For the first twelve (12) weeks following the Termination Effective Date, Medical Mutual Services shall continue to invoice the Group weekly as described in Section 2A of this Addendum I.

C. After the first twelve weeks following the Termination Effective Date, Medical Mutual Services will invoice the Group Paid Claims monthly or less frequently, through the twelfth (12th) month after the Termination Effective Date. Payment of each invoice is due within ten (10) days of the date of the invoice.

D. Following the Termination Effective Date, Medical Mutual Services will continue to invoice the Group for Out of State Surcharges and Access Fees.

E. Medical Mutual Services will not process, pay or adjust any claims after the twelfth (12th) month following the Termination Effective Date and any claims submitted thereafter, if payable, in whole or in part, under the applicable Benefit Book(s) or Certificate(s) shall be the Group's payment responsibility solely and shall not be a liability of Medical Mutual Services.

F. Following the Termination Effective Date, if Medical Mutual Services receives any checks for payment of subrogation claims, Medical Mutual Services will forward those amounts to the Group, less any amounts related to the third party claim paid under applicable stop loss insurance for the Covered Person.

G. For three consecutive months following the Termination Effective Date, Medical Mutual Services will invoice the Group for the Administrative Fee per Participant times the greater of the number of Participants in effect in each applicable section at the Termination Effective Date or the average number of Participants in effect in each applicable section for the three (3) months immediately prior to the Termination Effective Date. The Group shall pay the invoiced amounts within ten (10) days of the date of each invoice.

H. If the Group does not pay any invoiced amount due on the date specified for payment, Medical Mutual Services may suspend payment of claims and any other responsibilities it may have after the Termination Effective Date until payment is received.

IN WITNESS WHEREOF, the Group and Medical Mutual Services have signed this Addendum I:

City of Elyria (the Group)	**Medical Mutual Services, L.L.C.** (Medical Mutual Services)
Richard Jackson Signature	Signature
DIRECTOR - HR Title	Title
5-9-14 Date	Date

MEDICAL MUTUAL SERVICES, L.L.C.

EXHIBIT A
to
Addendum I
for
City of Elyria
Number 722263
February 1, 2014 through December 31, 2014

Administrative Fees:

Medical	$48.15*
Drug	$1.54
Dental	$3.47

**includes $10.00 commission*

The medical Administrative Fee for section 002 (Prisoners) will be 20% of the Provider Discount for claims in section 002.

Drug rebates, as set forth in the attached Amendment entitled "Pharmacy Rebates", will be $16.40 per retail brand script and $56.80 per mail order brand script.

Enrollment: 448

Medical Mutual Services, L. L. C.

Amendment to Addendum I

Pharmacy Rebates

This Amendment is incorporated into the Agreement between Medical Mutual Services, L. L. C. (Medical Mutual Services) and City of Elyria. In the event of a conflict between this Amendment and the underlying Agreement, the terms of the Amendment shall take precedence. This Amendment is effective on February 1, 2014, regardless of the date signed below.

RECITALS

(1) Medical Mutual Services and the Plan Sponsor have entered into an Agreement wherein Medical Mutual Services processes hospital, medical and prescription drug claims on behalf of the Plan Sponsor's Covered Persons.

(2) Medical Mutual Services contracts with a pharmacy benefits manager to obtain discounts on prescription drugs and to obtain access to a pharmacy network.

(3) Medical Mutual Services is entitled to certain drug rebates from the pharmacy benefits manager based on a number of factors.

(4) Medical Mutual Services has agreed with the Plan Sponsor to share the drug rebates with the Plan Sponsor and both parties agree that the Agreement should be amended to reflect the understanding of the parties with respect to the drug rebates.

NOW, THEREFORE, in consideration of the mutual promises contained herein, the parties hereby agree to the following:

PROVISIONS

1. Medical Mutual Services has agreed to share a certain amount of pharmacy rebates with the Plan Sponsor. This amount is set forth on Exhibit A to Addendum I

2. Medical Mutual Services has entered into a contract with Express Scripts, Inc. (Express Scripts) to provide pharmacy benefit and network services to Medical Mutual Services' covered groups.

3. Drug rebates in the Express Scripts contract are based on the number of prescriptions eligible for rebate, as shown on Exhibit A, filled by Medical Mutual Services' Covered Persons. The final rebate amounts are calculated pursuant to the contract with Express Scripts.

4. Medical Mutual Services and the Plan Sponsor agree that the Plan Sponsor's share of any rebates will be based on the amounts shown on Exhibit A to Addendum I per prescription eligible for rebate, as shown on Exhibit A.

5. These rebates will be available to the Plan Sponsor only so long as the Agreement with Medical Mutual Services is in effect and so long as the contract between Medical Mutual Services and Express Scripts is in effect.

Other than as amended above, the terms and conditions set forth in the Agreement remain unchanged.

City of Elyria	**Medical Mutual Services, L.L.C.**
Richard Jackson	
Signature	Signature
5-9-14	
Date	Date

RENEWAL
ADDENDUM I
ASO WEEKLY INVOICING

This Addendum to the Agreement between **City of Elyria #722263** (the "Group") and Medical Mutual Services, L. L. C. ("Medical Mutual Services") is an amendment to the Agreement and supersedes any prior invoicing Addendum and has been adopted pursuant to the section of the Agreement entitled "Amendments".

Section 1: Definitions

A. Agreement Period: The period beginning **January 1, 2015** through December 31, 2015.

B. Incurred Claim: A claim for Covered Services, as defined in the applicable Benefit Book(s), that has beginning service dates on or after the effective date of the Agreement and prior to the Termination Effective Date of the Agreement.

C. Adjudicated Claim: An Incurred Claim which has been processed and approved for payment but has not been released for payment by Medical Mutual Services.

D. Paid Claim: An Adjudicated Claim for which Medical Mutual Services has reimbursed the Provider or Participant on behalf of the Group. A claim is considered a Paid Claim as of the date shown on the check written by Medical Mutual Services. Claim Amounts will be paid in accordance with Medical Mutual Service's claims disbursement schedule.

E. Paid Claim Amount: The amount Medical Mutual Services pays to the Provider or the Participant for the individual claim, after the claim has been adjudicated and released for payment.

(i) For claims at hospitals and other institutions, the Paid Claim Amount shall not include adjustments or settlements due to maximum charge increase limitation violations, prompt payment discounts, or any settlement, incentive, allowance or adjustment that does not accrue to a specific claim at the time of adjudication.

(ii) For claims involving physicians or other professional providers, the Paid Claim Amount is not reduced by performance withholds.

(iii) For claims involving prescription drugs dispensed for use, the Paid Claim Amount does not include any formulary reimbursement savings, volume-based credits or refunds or discount guarantees.

(iv) In certain circumstances, Medical Mutual Services, through an affiliated company, may have an agreement or arrangement with a vendor which purchases services, supplies or products from Providers instead of Medical Mutual Services contracting directly with Providers themselves. Medical Mutual Services' agreement or arrangement with that vendor may not include the vendor's purchase price from the Provider, but may be based on some other financial arrangement such as a guaranteed discount.

The Paid Claim Amounts, in these circumstances, will be based on the network's re-pricing agreement with the vendor and not upon the vendor's actual purchase price with the Provider, subject to any further conditions or limitations set forth herein. Vendors include, but are not limited to, pharmacy providers, other managed care providers, home health providers and other provider networks.

(v) When the Covered Person receives services outside of the State of Ohio the claims for Covered Services will be processed whenever possible through a vendor relationship with another provider network with which Medical Mutual Services has contracted. The Paid Claim Amount for a claim submitted by an out of state provider will be based on the contractual arrangement the provider has with the network program. If the Plan's primary network does not have an arrangement with the provider, Medical Mutual Services will attempt to arrange for a discount through a secondary network. In such cases, any fees to obtain the discount will be included in the Paid Claim Amount. If there is no Agreement with a network provider, the Paid Claim Amount will be based on Net Covered Charges. The Group shall not be entitled to any further reduction or adjustment in the price of the claim other than what Medical Mutual Services receives from the network program.

F. Covered Charges: the charges for Covered Services, as defined in the applicable Benefits Book(s).

G. Net Covered Charges: Covered Charges less any deductibles, copayments, coinsurance or other patient liabilities and any amounts paid by other parties resulting from coordination of benefits, subrogation, workers' compensation and other party liability.

H. Administrative Fee: The monthly amount paid to Medical Mutual Services by the Group to cover administrative and other expenses per Participant per month. The Administrative Fee is specified in Exhibit A.

I. Provider Discount: Covered Charges minus the Allowed Amount.

J. Allowed Amount: For PPO network Providers and contracting Providers, the Allowed Amount is the lesser of Medical Mutual Services' negotiated amount with the Provider or the Provider's billed charges. For non-contracting Providers, the Allowed Amount is Medical Mutual Services' non-contracting rate, which is the maximum amount allowed by Medical Mutual Services for Covered Services provided by a non-contracting Provider. The non-contracting rate is based on various factors, including, but not limited to, market rates for that service, negotiated amounts with PPO network Providers for that service, and Medicare reimbursement rates for that service.

K. Taxes and Out of State Surcharges: The States of New York, Massachusetts and Michigan have enacted legislation which imposes surcharges on certain health care costs incurred by Covered Persons receiving services in those states. Medical Mutual Services will pay the Out of State Surcharges directly to each state for the Group. The Group will be invoiced for actual Out of State Surcharges paid by Medical Mutual Services. Payment is due in accordance with the terms of the invoice. No additional Administrative Fee will be charged for this service. The same procedure will apply if other states pass similar legislation.

If any other tax (other than state or federal income taxes) or any other assessment or fee is assessed against the Plan, the claims administrator shall have no obligation to pay such tax, assessment or fee. The Group shall pay such tax, assessment or fee, once it determines it is subject to it. If Medical Mutual Services pays any such taxes, assessments or fees on behalf of the Group, the Group agrees to reimburse Medical Mutual Services for the full amount of such taxes, assessments or fees.

L. Termination Effective Date: 12:01 a.m. on the date the Agreement terminates for the group, any line(s) of business or any section(s) thereof, as specified pursuant to a written termination notice from one party to the other.

M. Access Fees: Amounts paid to Medical Mutual Services and/or the provider network(s) by the Group for use of the provider network(s).

Section 2: Invoicing

A. Weekly Invoices: Throughout the Agreement Period Medical Mutual Services shall invoice the Group each week for claims paid by Medical Mutual Services during the preceding week, and for Stop Loss credits as notified by the Stop Loss carrier. The Group will pay the invoiced amounts on the second business day following the date of the invoice. If payment of the invoice is not received when due, Medical Mutual Services will suspend processing of the group's claims and will not release future claim payments until payment is received from the Group.

B. Monthly Invoices: Throughout the Agreement Period Medical Mutual Services shall issue on a monthly basis an invoice for the Administrative Fee and for Stop Loss Premiums, on behalf of the Stop Loss Carrier. In addition, Medical Mutual Services shall issue a separate invoice on a monthly basis for the month's claims less amounts paid for weekly invoices for the month. Payment for each monthly invoice will be due to Medical Mutual Services on the first of each month or within ten (10) days of the date of the invoice, whichever is later. If the invoice is not paid when due, Medical Mutual Services will suspend payment of the group's claims and will not release future claim payments until payment is received from the Group.

C. Without waiving any other remedies Medical Mutual Services may have for non-payment or late payment by the Group of any amounts billed by Medical Mutual Services, including, but not limited to, Claims, Monthly Invoices and Out of State Surcharges, Medical Mutual Services reserves the right to change the Plan's claims invoicing method, described in 2A above, and will bill for claims adjudicated rather than claims paid. This means that Medical Mutual Services will invoice the Group for claims that are ready to be paid, but will not release those payments until funds for such claims are received from the Group. The change to an adjudicated invoicing method will commence immediately upon notification to the Group.

D. Medical Mutual Services, through an affiliated company, has Agreements with Providers, including hospitals. Some of these Agreements with Providers allow discounts, allowances, incentives, adjustments and settlements. These amounts are for the sole benefit of Medical Mutual Services and Medical Mutual Services will retain certain of the payments resulting therefrom as more fully set forth in Section 1E hereof. In any event, however, Paid Claim Amounts shall be calculated as provided herein, and deductibles, copayments, coinsurance and benefit accumulations shall be calculated as set forth in Addendum III or the Benefit Book(s).

E. The Group acknowledges and understands that the Paid Claim Amount may exceed the amount of Net Covered Charges for the Covered Services and that some of its payment responsibilities are nevertheless based on the Paid Claim Amounts and not upon the lesser of Net Covered Charges or the Paid Claim Amount.

Section 3: Management Reports

Medical Mutual Services shall prepare the following standard management reports for the Group:

Monthly Claims Detail
Annual Renewal Package
Quarterly Reporting Package

Reports or analyses not listed herein may be provided by Medical Mutual Services for a reasonable fee upon request of the Group.

Section 4: Changes to the Funding Arrangement

A. At least thirty (30) days prior to the renewal date of the Agreement, Medical Mutual Services will notify the Group of any changes in the Administrative Fees, Access Fees or other fee(s) and Agreement terms.

B. Medical Mutual Services reserves the right to adjust the fees, premiums and liability limits for the Agreement Period if the group's monthly enrollment changes, either in aggregate or for a specific line of business, by ten percent (10%) from the expected monthly enrollment specified in Exhibit A. Any adjustment in fees or liability limits will be effective as of the date of the change in enrollment.

Section 5: Termination

If the Agreement terminates for the group, line(s) of business or any section(s) thereof:

A. Medical Mutual Services will continue to process Incurred Claims where the incurred date(s) preceded the Termination Effective Date and which were received by Medical Mutual Services in accordance with the Group's applicable Benefit Book(s) and this Addendum I.

B. For the first twelve (12) weeks following the Termination Effective Date, Medical Mutual Services shall continue to invoice the Group weekly as described in Section 2A of this Addendum I.

C. After the first twelve weeks following the Termination Effective Date, Medical Mutual Services will invoice the Group Paid Claims monthly or less frequently, through the twelfth (12th) month after the Termination Effective Date. Payment of each invoice is due within ten (10) days of the date of the invoice.

D. Following the Termination Effective Date, Medical Mutual Services will continue to invoice the Group for Out of State Surcharges and Access Fees.

E. Medical Mutual Services will not process, pay or adjust any claims after the twelfth (12th) month following the Termination Effective Date and any claims submitted thereafter, if payable, in whole or in part, under the applicable Benefit Book(s) or Certificate(s) shall be the Group's payment responsibility solely and shall not be a liability of Medical Mutual Services.

F. Following the Termination Effective Date, if Medical Mutual Services receives any checks for payment of subrogation claims, Medical Mutual Services will forward those amounts to the Group, less any amounts related to the third party claim paid under applicable stop loss insurance for the Covered Person.

G. For three consecutive months following the Termination Effective Date, Medical Mutual Services will invoice the Group for the Administrative Fee per Participant times the greater of the number of Participants in effect in each applicable section at the Termination Effective Date or the average number of Participants in effect in each applicable section for the three (3) months immediately prior to the Termination Effective Date. The Group shall pay the invoiced amounts within ten (10) days of the date of each invoice.

H. If the Group does not pay any invoiced amount due on the date specified for payment, Medical Mutual Services may suspend payment of claims and any other responsibilities it may have after the Termination Effective Date until payment is received.

IN WITNESS WHEREOF, the Group and Medical Mutual Services have signed this Addendum I:

City of Elyria (the Group)	**Medical Mutual Services, L.L.C.** (Medical Mutual Services)
Holly C. Brunda Signature	Signature
1-29-15 Mayor Title	Title
1-29-15 Date	Date

MEDICAL MUTUAL SERVICES, L.L.C.

EXHIBIT A
to
Addendum I
for
City of Elyria
Number 722263
January 1, 2015 through December 31, 2015

Administrative Fees:

Medical	$49.29*
Drug	$1.54
Dental	$3.57

**includes $10.00 commission*

The medical Administrative Fee for section 002 (Prisoners) will be 20% of the Provider Discount for claims in section 002.

Drug rebates, as set forth in the attached Amendment entitled "Pharmacy Rebates", will be $16.40 per retail brand script and $56.80 per mail order brand script.

Enrollment: 437

Medical Mutual Services, L. L. C.

Amendment to Addendum I

Pharmacy Rebates

This Amendment is incorporated into the Agreement between Medical Mutual Services, L. L. C. (Medical Mutual Services) and City of Elyria. In the event of a conflict between this Amendment and the underlying Agreement, the terms of the Amendment shall take precedence. This Amendment is effective on January 1, 2015, regardless of the date signed below.

RECITALS

(1) Medical Mutual Services and the Plan Sponsor have entered into an Agreement wherein Medical Mutual Services processes hospital, medical and prescription drug claims on behalf of the Plan Sponsor's Covered Persons.

(2) Medical Mutual Services contracts with a pharmacy benefits manager to obtain discounts on prescription drugs and to obtain access to a pharmacy network.

(3) Medical Mutual Services is entitled to certain drug rebates from the pharmacy benefits manager based on a number of factors.

(4) Medical Mutual Services has agreed with the Plan Sponsor to share the drug rebates with the Plan Sponsor and both parties agree that the Agreement should be amended to reflect the understanding of the parties with respect to the drug rebates.

NOW, THEREFORE, in consideration of the mutual promises contained herein, the parties hereby agree to the following:

PROVISIONS

1. Medical Mutual Services has agreed to share a certain amount of pharmacy rebates with the Plan Sponsor. This amount is set forth on Exhibit A to Addendum I

2. Medical Mutual Services has entered into a contract with Express Scripts, Inc. (Express Scripts) to provide pharmacy benefit and network services to Medical Mutual Services' covered groups.

3. Drug rebates in the Express Scripts contract are based on the number of prescriptions eligible for rebate, as shown on Exhibit A, filled by Medical Mutual Services' Covered Persons. The final rebate amounts are calculated pursuant to the contract with Express Scripts.

4. Medical Mutual Services and the Plan Sponsor agree that the Plan Sponsor's share of any rebates will be based on the amounts shown on Exhibit A to Addendum I per prescription eligible for rebate, as shown on Exhibit A.

5. These rebates will be available to the Plan Sponsor only so long as the Agreement with Medical Mutual Services is in effect and so long as the contract between Medical Mutual Services and Express Scripts is in effect.

Other than as amended above, the terms and conditions set forth in the Agreement remain unchanged.

City of Elyria	**Medical Mutual Services, L.L.C.**
Nelly C. Brinda	
Signature	Signature
1-29-15	
Date	Date

Exhibit 3

AMENDMENT

to the Administrative Services Agreement for
City of Lorain

This Amendment modifies the Administrative Services Agreement (the Agreement), dated February 1, 2010, entered into between **City of Lorain #848483** (the "Plan Sponsor") and Medical Mutual Services, L.L.C. (Medical Mutual Services).

The Effective Date of this Amendment is **February 1, 2013** at 12:01 a.m., regardless of the date executed by the parties. Except as modified specifically herein, all terms and conditions of the Agreement remain unchanged.

1) Article III Section 3.2, Section 3.5 and Section 3.6 are revised as follows. In addition, Section 3.7 and Section 3.8 are added to Article III:

Section 3.2 The Plan Sponsor shall provide Medical Mutual Services with copies of the Summary Plan Description and amendments thereto in a timely manner after adoption and execution of the same. The Plan Sponsor agrees that Benefit Books may be reviewed by Medical Mutual Services to ensure compliance with Medical Mutual Services' claims processing procedures.

If Medical Mutual does not prepare Benefit Books for Plan Sponsor, Plan Sponsor understands that Medical Mutual will not begin processing claims under this Agreement until Plan Sponsor has provided Medical Mutual with its most recent Summary Plan Description and/or benefit plan booklet, to ensure Medical Mutual can accurately administer claims for benefits, utilization review and medical policy under the Plan.

The Plan may be amended by the Plan Sponsor at its discretion. The Plan Sponsor shall give Medical Mutual Services written notice of any such amendment at least sixty (60) days before its effective date. It is the Plan Sponsor's obligation to notify Participants of any changes and the effective dates thereof and provide any required Summary of Material Modification. Any change in the nature of the services provided by Medical Mutual Services under this Agreement that would be caused by their amendment, must be approved in writing by Medical Mutual Services for the change in services to be included under this Agreement. Any such approved change shall also be a basis for Medical Mutual Services to request re-negotiation of the fee paid to Medical Mutual Services by the Plan Sponsor.

In the event the parties cannot agree on a new fee within thirty (30) days of the date Medical Mutual Services received written notice of the amendment, Medical Mutual Services shall have no obligation to provide the changed services and Medical Mutual Services may terminate this Agreement upon thirty (30) days prior written notice to the Plan Sponsor.

Section 3.5 The Plan Sponsor shall be financially liable for claims incurred by a Covered Person and paid by Medical Mutual Services prior to receipt from the Plan Sponsor of written or electronic notification of the termination of such Covered Person's enrollment in the Plan. The Plan Sponsor must provide Medical Mutual with written notice of any change in a person's eligibility under this Agreement in a prompt and timely manner and, in no circumstance, any later than thirty-one (31) days after the change occurs. In some situations, when an individual pays no premium (including COBRA premium) following termination of eligibility, the Plan Sponsor 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. Medical Mutual will not recoup on behalf of the Plan Sponsor payments made to Providers in situations where rescission is not permitted by law. In the limited instances where retroactive termination is permitted by law, Medical Mutual Services will attempt to recoup payments made for former Participants who have been retroactively deleted from eligibility and credit the amounts recouped in the next billing cycle after the adjustment is processed.

Section 3.6 The Plan Sponsor shall furnish, in a prompt and timely manner, all information regarding the Plan and Covered Persons required by Medical Mutual Services to perform its obligations under this Agreement.

Section 3.7 The Plan Sponsor shall be responsible for reimbursing the Centers for Medicare & Medicaid Services (CMS) (or its designee) for any liability which may be imposed on the Plan under the Medicare Secondary Payer laws where the Plan paid claims on behalf of an individual on a secondary basis when in fact the Plan should have been primary to Medicare. The Plan Sponsor's liability shall remain in force and shall survive the termination of this Agreement. In no event will Medical Mutual Services assume responsibility for the Plan's liability under the Medicare Secondary Payer rules. In addition, the Plan Sponsor shall reimburse Medical Mutual Services for any costs or expenses incurred by Medical Mutual Services in determining such liability.

Section 3.8 Because a reduction in the Plan Sponsor's premium contribution can impact the Plan's grandfathered status, the Plan Sponsor must notify Medical Mutual Services 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.

2) Article IV is replaced in its entirety with the following:

ARTICLE IV
TERMINATION

Section 4.1 The initial term of the Agreement shall be for a period of twelve (12) months beginning on the Effective Date. Unless canceled or terminated earlier as provided for by this Agreement, the Agreement will renew for a further period of twelve (12) consecutive months and thereafter, from year to year. Renewal may be subject to new Administrative Fees and changes to Agreement terms. Except as provided below, Medical Mutual Services will provide 60 days' notice of its intent not to renew the Agreement.

The Plan Sponsor may cancel or terminate this Agreement without cause only upon thirty (30) days written notice to Medical Mutual Services. Medical Mutual Services may cancel or terminate this Agreement at any time without notice if the Plan Sponsor fails to pay the amounts required by this Agreement. Medical Mutual Services' negotiation of any check sent or deposited into Medical Mutual Services' lockbox after the termination date does not constitute acceptance or reinstatement by Medical Mutual Services. Medical Mutual Services may also cancel or terminate this Agreement with thirty (30) days written notice in the event of fraud or misrepresentation by the Plan Sponsor.

Either party may terminate this Agreement in the event of a material breach of the terms of this Agreement by the other party, other than for a failure to pay as described in the immediately preceding paragraph. Such termination shall be effective thirty (30) days after written notice of the breach is delivered to the breaching party, unless the breach has been cured before the end of the thirty (30) day period.

If the Agreement is canceled or terminated, the Plan Sponsor must notify in writing all of its Participants of the cancellation or termination.

Section 4.2 Additionally, this Agreement shall automatically terminate as of the effective date of any legislative enactment which makes illegal the continuation of the Plan and/or this Agreement;

Section 4.3 If the Plan Sponsor fails to make any payment required by this Agreement when due, Medical Mutual Services may suspend processing of claims commencing on the day after such payment was due.

Section 4.4 The Plan Sponsor shall be liable for all Administrative Fees and claim payments due to Medical Mutual Services upon termination of this Agreement, as specifically described in the attached Addendum I.

Section 4.5 If this Agreement terminates, any claims not paid as of the Termination Effective Date shall be administered as described in Addendum I, Section 5.

3) The following provision is deleted from Article VIII. Section 8.11 in the Agreement is renumbered as Section 8.10.

Section 8.10 Exclusivity

Plan Sponsor agrees that the self funded health plan administered by Medical Mutual Services shall be the only group health plan (other than a flexible spending account) offered to Covered Persons during the term of this Agreement and Plan Sponsor shall not enter into an agreement with any other third party administrator or insurer to provide or administer health benefits on behalf of Covered Persons. Should Plan Sponsor violate this section of the Agreement, the early termination penalty provisions set forth in Section 6 of Addendum I shall apply as of the first date that Medical Mutual Services is not the exclusive administrator of health benefits provided to the Plan Sponsor.

4 Addendum I, ASO Weekly Invoicing, of the Agreement is replaced with the following Addendum.

ADDENDUM I
ASO WEEKLY INVOICING

This Addendum to the Agreement between **City of Lorain #848483** (the "Plan Sponsor") and Medical Mutual Services, L. L. C. ("Medical Mutual Services") is an amendment to the Agreement and supersedes any prior invoicing Addendum and has been adopted pursuant to the section of the Agreement entitled "Amendments".

Section 1: Definitions

A. Agreement Period: The period beginning **February 1, 2013** through January 31, 2014.

B. Incurred Claim: A claim for Covered Services, as defined in the applicable Benefit Book(s), that has beginning service dates on or after the effective date of the Agreement and prior to the Termination Effective Date of the Agreement.

C. Adjudicated Claim: An Incurred Claim which has been processed and approved for payment but has not been released for payment by Medical Mutual Services.

D. Paid Claim: An Adjudicated Claim for which Medical Mutual Services has reimbursed the Provider or Participant on behalf of the Plan Sponsor. A claim is considered a Paid Claim as of the date shown on the check written by Medical Mutual Services. Claim Amounts will be paid in accordance with Medical Mutual Service's claims disbursement schedule.

E. Paid Claim Amount: The amount Medical Mutual Services pays to the Provider or the Participant for the individual claim, after the claim has been adjudicated and released for payment.

(i) For claims at hospitals and other institutions, the Paid Claim Amount shall not include adjustments or settlements due to maximum charge increase limitation violations, prompt payment discounts, or any settlement, incentive, allowance or adjustment that does not accrue to a specific claim at the time of adjudication.

(ii) For claims involving prescription drugs dispensed for use, the Paid Claim Amount does not include any formulary reimbursement savings, volume-based credits or refunds or discount guarantees.

(iii) In certain circumstances, Medical Mutual Services, through an affiliated company, may have an agreement or arrangement with a vendor which purchases services, supplies or products from Providers instead of Medical Mutual Services contracting directly with Providers themselves. Medical Mutual Services' agreement or arrangement with that vendor may not include the vendor's purchase price from the Provider, but may be based on some other financial arrangement such as a guaranteed discount.

The Paid Claim Amounts, in these circumstances, will be based on the network's re-pricing agreement with the vendor and not upon the vendor's actual purchase price with the Provider, subject to any further conditions or limitations set forth herein. Vendors include, but are not limited to, pharmacy providers, other managed care providers, home health providers and other provider networks.

(iv) When the Covered Person receives services outside of the State of Ohio the claims for Covered Services will be processed whenever possible through a vendor relationship with another provider network with which Medical Mutual Services has contracted. The Paid Claim Amount for a claim submitted by an out of state provider will be based on the contractual arrangement the provider has with the network program. If the Plan's primary network does not have an arrangement with the provider, Medical Mutual Services will attempt to arrange for a discount through a secondary network. In such cases, any fees to obtain the discount will be included in the Paid Claim Amount. If there is no Agreement with a network provider, the Paid Claim Amount will be based on Net Covered Charges. The Plan Sponsor shall not be entitled to any further reduction or adjustment in the price of the claim other than what Medical Mutual Services receives from the network program.

F. Covered Charges: the charges for Covered Services, as defined in the applicable Benefits Book(s).

G. Net Covered Charges: Covered Charges less any deductibles, copayments, coinsurance or other patient liabilities and any amounts paid by other parties resulting from coordination of benefits, subrogation, workers' compensation and other party liability.

H. Administrative Fee: The monthly amount paid to Medical Mutual Services by the Plan Sponsor to cover administrative and other expenses per Participant per month. The Administrative Fee is specified in Exhibit A.

I. Provider Discount: Covered Charges minus the Paid Claim Amount.

J. Out of State Surcharges: The States of New York, Massachusetts and Michigan have enacted legislation which imposes surcharges on certain health care costs incurred by Covered Persons receiving services in those states. Medical Mutual Services will pay the Out of State Surcharges directly to each state for the Plan Sponsor. The Plan Sponsor will be invoiced for actual Out of State Surcharges paid by Medical Mutual Services. Payment is due in accordance with the terms of the invoice. No additional Administrative Fee will be charged for this service. The same procedure will apply if other states pass similar legislation.

If any other tax (other than state or federal income taxes) or any other assessment or fee is assessed against the Plan, the claims administrator shall have no obligation to pay such tax, assessment or fee. The Plan Sponsor shall pay such tax, assessment or fee, once it determines it is subject to it. If Medical Mutual Services pays any such taxes, assessments or fees on behalf of the Plan Sponsor, the Plan Sponsor agrees to reimburse Medical Mutual Services for the full amount of such taxes, assessments or fees.

K. Termination Effective Date: 12:01 a.m. on the date the Agreement terminates for the group, any line(s) of business or any section(s) thereof, as specified pursuant to a written termination notice from one party to the other.

L. Access Fees: Amounts paid to Medical Mutual Services and/or the provider network(s) by the Plan Sponsor for use of the provider network(s).

Section 2: Invoicing

A. Weekly Invoices: Throughout the Agreement Period Medical Mutual Services shall invoice the Plan Sponsor each week for claims paid by Medical Mutual Services during the preceding week, and for Stop Loss credits as notified by the Stop Loss carrier. The Plan Sponsor will pay the invoiced amounts on the second business day following the date of the invoice. Claim Amounts will be paid in accordance with Medical Mutual Service's claims disbursement schedule. If payment of the invoice is not received when due, Medical Mutual Services will suspend processing of the group's claims and will not release future claim payments until payment is received from the Plan Sponsor.

B. Monthly Invoices: Throughout the Agreement Period Medical Mutual Services shall issue on a monthly basis an invoice for the Administrative Fee and for Stop Loss Premiums, on behalf of the Stop Loss Carrier. In addition, Medical Mutual Services shall issue a separate invoice on a monthly basis for the month's claims less amounts paid for weekly invoices for the month. Payment for each monthly invoice will be due to Medical Mutual Services on the first of each month or within ten (10) days of the date of the invoice, whichever is later. If the invoice is not paid when due, Medical Mutual Services will suspend payment of the group's claims and will not release future claim payments until payment is received from the Plan Sponsor.

C. Without waiving any other remedies Medical Mutual Services may have for non-payment or late payment by the Plan Sponsor of any amounts billed by Medical Mutual Services, including, but not limited to, Claims, Monthly Invoices and Out of State Surcharges, Medical Mutual Services reserves the right to change the Plan's claims invoicing method, described in 2A above, and will bill for claims adjudicated rather than claims paid. This means that Medical Mutual Services will invoice the Plan Sponsor for claims that are ready to be paid, but will not release those payments until funds for such claims are received from the Plan Sponsor. The change to an adjudicated invoicing method will commence immediately upon notification to the Plan Sponsor.

D. Medical Mutual Services, through an affiliated company, has Agreements with Providers, including hospitals. Some of these Agreements with Providers allow discounts, allowances, incentives, adjustments and settlements. These amounts are for the sole benefit of Medical Mutual Services and Medical Mutual Services will retain certain of the payments resulting therefrom as more fully set forth in Section 1E hereof. In any event, however, Paid Claim Amounts shall be calculated as provided herein, and deductibles, copayments, coinsurance and benefit accumulations shall be calculated as set forth in Addendum III or the Benefit Book(s).

E. The Plan Sponsor acknowledges and understands that the Paid Claim Amount may exceed the amount of Net Covered Charges for the Covered Services and that some of its payment responsibilities are nevertheless based on the Paid Claim Amounts and not upon the lesser of Net Covered Charges or the Paid Claim Amount.

Section 3: Management Reports

Medical Mutual Services shall prepare the following standard management reports for the Plan Sponsor:

Monthly Claims Detail
Annual Renewal Package
Quarterly Reporting Package

Reports or analyses not listed herein may be provided by Medical Mutual Services for a reasonable fee upon request of the Plan Sponsor.

Section 4: Changes to the Funding Arrangement

A. At least sixty (60) days prior to the renewal date of the Agreement, Medical Mutual Services will notify the Plan Sponsor of any changes in the Administrative Fees, Access Fees or other fee(s) and Agreement terms.

B. Medical Mutual Services reserves the right to adjust the fees, premiums and liability limits for the Agreement Period if the group's monthly enrollment changes, either in aggregate or for a specific line of business, by ten percent (10%) from the expected monthly enrollment specified in Exhibit A. Any adjustment in fees or liability limits will be effective as of the date of the change in enrollment.

Section 5: Termination

If the Agreement terminates for the group, line(s) of business or any section(s) thereof:

A. Medical Mutual Services will continue to process Incurred Claims where the incurred date(s) preceded the Termination Effective Date and which were received by Medical Mutual Services in accordance with the Plan Sponsor's applicable Benefit Book(s) and this Addendum I.

B. For the first twelve (12) weeks following the Termination Effective Date, Medical Mutual Services shall continue to invoice the Plan Sponsor weekly as described in Section 2A of this Addendum I.

C. After the first twelve weeks following the Termination Effective Date, Medical Mutual Services will invoice the Plan Sponsor for Paid Claims monthly or less frequently, through the twelfth (12th) month after the Termination Effective Date. Payment of each invoice is due within ten (10) days of the date of the invoice.

D. Following the Termination Effective Date, Medical Mutual Services will continue to invoice the Plan Sponsor for Out of State Surcharges and Access Fees.

E. Medical Mutual Services will not process, pay or adjust any claims after the twelfth (12th) month following the Termination Effective Date and any claims submitted thereafter, if payable, in whole or in part, under the applicable Benefit Book(s) or Certificate(s) shall be the Plan Sponsor's payment responsibility solely and shall not be a liability of Medical Mutual Services.

F. Following the Termination Effective Date, if Medical Mutual Services receives any checks for payment of subrogation claims, Medical Mutual Services will forward those amounts to the Plan Sponsor, less any amounts related to the third party claim paid under applicable stop loss insurance for the Covered Person.

G. For three consecutive months following the Termination Effective Date, Medical Mutual Services will invoice the Plan Sponsor for the Administrative Fee per Participant times the greater of the number of Participants in effect in each applicable section at the Termination Effective Date or the average number of Participants in effect in each applicable section for the three (3) months immediately prior to the Termination Effective Date. The Plan Sponsor shall pay the invoiced amounts within ten (10) days of the date of each invoice.

H. If the Plan Sponsor does not pay any invoiced amount due on the date specified for payment, Medical Mutual Services may suspend payment of claims and any other responsibilities it may have after the Termination Effective Date until payment is received.

IN WITNESS WHEREOF, the Plan Sponsor and Medical Mutual Services have signed this Addendum I:

City of Lorain
(the Plan Sponsor)

Signature

Safety - Service Director
Title

1/29/13
Date

Medical Mutual Services, L.L.C.
(Medical Mutual Services)

Signature

Corporate Secretary
Title

FEB 13 2013
Date

MEDICAL MUTUAL SERVICES, L.L.C.

EXHIBIT A
to
Addendum I
for
City of Lorain #848483

February 1, 2013 through January 31, 2014

Administrative Fee(s):*

Medical	$37.42
Drug	$0.40 per script

February 1, 2014 through January 31, 2015

Administrative Fee(s):*

Medical	$38.17

February 1, 2015 through January 31, 2016

Administrative Fee(s):*

Medical	$38.93

Drug Administrative Fee and Rebates will be negotiated annually.

*This rate guarantee does not include and does not apply to fees, taxes or other charges imposed on Medical Mutual by state or federal government laws, statutes or regulations. To the extent permitted by law, Medical Mutual Services will include such charges in the fees charged to the Plan Sponsor or may include them as separate line item on the Plan Sponsor's invoice.

Enrollment: 445

Drug rebates:

Retail (brand scripts)	$18.29
Mail Order (brand scripts)	$63.32

EXHIBIT B

Discount Guarantee

Guaranteed Minimum Provider Discount: 54%

Medical Mutual Services will provide City of Lorain a discount guarantee of at least 54% for Ohio PPO medical services for which Medical Mutual Services coverage is primary. If the actual discount achieved by Medical Mutual Services for the 2013 contract year is less than the guarantee, Medical Mutual Services will reimburse City of Lorain for 3% of the administrative fee for each 1% discount less than the 54% guarantee, with a maximum reimbursement of 15% of the Administrative Fees. See table below. The discount guarantee measurement will be based on claims paid from 2/01/2013 through 1/31/2014.

Discount Achieved	*Administrative Fee Reimbursement*
54% - 100%	0%
>= 53%, < 54%	3.00%
>= 52%, < 53%	6.00%
>= 51%, < 52%	9.00%
>= 50%, < 51%	12.00%
>= 49%, < 50%	15.00%

Administrative fees include Medical Administrative Fees only. This discount guarantee is subject to change if enrollment varies by 10% or more and/or the geographic distribution of members changes significantly.

(Total fees at risk, twenty seven percent (27%), when combined with a maximum of twelve percent (12%) in penalties for the Performance Guarantees set forth in Addendum IV.)

The Guaranteed Minimum Provider Discount assumes the Provider agreements and/or network composition agreements are not limited by or materially changed by any applicable laws or regulations. If a hospital freezes or reduces its charge master (Billed Charges) during an Agreement Period, Medical Mutual will assume the lesser of CPI-medical or 3.5% increase in charges for calculation of the discount guarantee, provided Medical Mutual can demonstrate that it would have met or exceeded the discount guarantee but for the hospital freezing or reducing its charge master. Amounts paid to Providers as part of a quality incentive program or fund are not included in the calculation of the guaranteed discount.

Medical Mutual Services, L. L. C.

Amendment to Addendum I

Pharmacy Rebates

This Amendment is incorporated into the Agreement between Medical Mutual Services, L. L. C. (Medical Mutual Services) and City of Lorain. In the event of a conflict between this Amendment and the underlying Agreement, the terms of the Amendment shall take precedence. This Amendment is effective on February 1, 2013, regardless of the date signed below.

RECITALS

(1) Medical Mutual Services and the Plan Sponsor have entered into an Agreement wherein Medical Mutual Services processes hospital, medical and prescription drug claims on behalf of the Plan Sponsor's Covered Persons.

(2) Medical Mutual Services contracts with a pharmacy benefits manager to obtain discounts on prescription drugs and to obtain access to a pharmacy network.

(3) Medical Mutual Services is entitled to certain drug rebates from the pharmacy benefits manager based on a number of factors.

(4) Medical Mutual Services has agreed with the Plan Sponsor to share the drug rebates with the Plan Sponsor and both parties agree that the Agreement should be amended to reflect the understanding of the parties with respect to the drug rebates.

NOW, THEREFORE, in consideration of the mutual promises contained herein, the parties hereby agree to the following:

PROVISIONS

1. Medical Mutual Services has agreed to share a certain amount of pharmacy rebates with the Plan Sponsor. This amount is set forth on Exhibit A to Addendum I

2. Medical Mutual Services has entered into a contract with Express Scripts, Inc. (Express Scripts) to provide pharmacy benefit and network services to Medical Mutual Services' covered groups.

3. Drug rebates in the Express Scripts contract are based on the number of prescriptions eligible for rebate, as shown on Exhibit A, filled by Medical Mutual Services' Covered Persons. The final rebate amounts are calculated pursuant to the contract with Express Scripts.

4. Medical Mutual Services and the Plan Sponsor agree that the Plan Sponsor's share of any rebates will be based on the amounts shown on Exhibit A to Addendum I per prescription eligible for rebate, as shown on Exhibit A.

5. These rebates will be available to the Plan Sponsor only so long as the Agreement with Medical Mutual Services is in effect and so long as the contract between Medical Mutual Services and Express Scripts is in effect.

Other than as amended above, the terms and conditions set forth in the Agreement remain unchanged.

City of Lorain

Signature

1/29/13
Date

Medical Mutual Services, L.L.C.

Signature

FEB 13 2013
Date

Addendum IV
Performance Guarantees
City of Lorain
#848483

This Addendum modifies the Administrative Services Agreement (the Agreement) between City of Lorain (the Plan Sponsor) and Medical Mutual Services, L.L.C. (Medical Mutual Services). Except as specifically modified herein, all other terms and conditions of the Agreement are unchanged. This Addendum is effective on **February 1, 2013**, regardless of the date signed below.

Medical Mutual Services will calculate penalties on an annual basis. No penalties will be applied for performance guarantees for the first three (3) months following the effective date of new agreements or material changes to the Plan benefit structure, including renewals, in order to allow implementation to occur.

No penalties will be paid for any months during which the Agreement or the Renewal Addendum I to the Agreement remains unsigned by the Plan Sponsor beyond the initial three-month waiver.

Settlement for failure to achieve targeted objectives will be finalized within thirty (30) days of a final report from an independent auditor performed pursuant to Section 6.3 of the Agreement.

Any changes to the Claims Timeliness standard will follow modifications to existing Ohio Department of Insurance law and guidelines if/when they occur.

Guarantees shown in the chart marked Exhibit A to Addendum IV.

Total Paid Administrative Fees at Risk: Twenty Seven Percent (27%) - Performance and Provider Discount Guarantees combined (Provider Discount Guarantee shown on Exhibit A to Addendum I)

FORCE MAJEURE

In the application of the penalty provisions of the performance guarantees if Medical Mutual Services is unable to carry out any obligation of the Agreement to which such performance guarantees are applicable by reason of force majeure, a penalty shall not be imposed within the time period for which performance is being or is to be measured. The term "force majeure" as used herein shall include acts of God, earthquake, fire, explosion, failure of electrical power or other utility affecting the equipment utilized in the processing of claims, or other casualty, strike or other concerted activity, and provided that Medical Mutual commences or resumes its activities immediately after such causes no longer exist.

IN WITNESS WHEREOF, the parties have affixed their signatures.

City of Lorain
(the Plan Sponsor)

Signature

S/S Director
Title

1/29/13
Date

Medical Mutual Services, L.L.C.
(Medical Mutual Services)

Signature

Title

FEB 13 2013
Date

EXHIBIT A
TO
ADDENDUM IV
City of Lorain
#848483

Average speed of answer – wait time	Defined as the amount of time (in seconds) beginning from the time a call reaches the telephone system queue until it is answered by a live customer service representative. Call center business hours of operation: Mon. - Thurs. 7:30am – 7:30pm Fri. 7:30am – 6:00pm Sat. 9:00am – 1:00pm	Average speed of answer by a live customer service representative will be 30 seconds or less during regular business hours. 1% at risk if greater than 30 seconds 2% at risk if greater than 45 seconds
Abandonment Rate	Measured as the percentage of all member calls where the caller hangs up before the call is answered by a live customer service representative.	Target = 5% 1% at risk if greater than 5% 2% at risk if greater than 7%
ID Card Production	Percent of ID cards mailed within a specified time period.	ID cards will be provided within an average of 8 calendar days of receipt of "readable" eligibility information. 1% at risk if ID cards mailed within an average of 9 calendar days or greater.
Claim Financial Accuracy	Total sample claim dollars paid without error divided by total sample claim dollars paid. Both overpayment and underpayment errors are measured in absolute dollars and do not offset one another.	Target = 99% 1% at risk if less than 99% 2% at risk if less than 97%
Claim Turnaround Time	Claims turnaround time is measured from corporate receipt date to check date. Time to obtain information from outside entities (Provider, Subscriber or Plan Sponsor) is deducted from overall age of claim.	95% of all claims will be paid within 30 calendar days. 1% at risk if less than 95% 2% at risk if less than 94% 3% at risk if less than 93%

Claim Payment Accuracy	Total number of paid claims within a statistical sample which contain one or more financial errors divided by the total number of claims within the sample expressed as a percentage.	Target = 97% 1% at risk if less than 97% 2% at risk if less than 95%

Account Management	Satisfaction with services provided by Vendor.	Medical Mutual Sales team will provide services based on mutually agreeable servicing guidelines. At the end of the Agreement Period, a comprehensive review will occur between Medical Mutual and the Plan Sponsor to determine if services provided were satisfactory. If any servicing issues exist, an action plan will be developed between Medical Mutual and the Plan Sponsor to document areas for improvement. No dollars at risk

***Total Paid Administrative Fees at Risk**: Twenty Seven Percent (27%) - Performance and Provider Discount Guarantees combined (Provider Discount Guarantee shown on Exhibit A to Addendum I)*