ORDINANCE NO. 130-17

AN ORDINANCE AMENDING SECTIONS 31.13 (2)(C) AND 31.16 OF THE SALARIES AND BENEFITS CODE OF THE CITY OF MEDINA, OHIO RELATIVE TO VACATION AND GROUP HOSPITALIZATION, AND DECLARING AN EMERGENCY.

WHEREAS: Section 31.13 (2) (C) of the Salaries and Benefits Code of the City of Medina, Ohio presently reads as follows pertaining to Vacation:

A. Basic Work Week. A basic work week as used in Article 16.

WHEREAS: Section 31.16 of the Salaries and Benefits Code of the City of Medina, Ohio presently reads as follows relating to Group Hospitalization:

SECTION 31.16 GROUP HOSPITALIZATION INSURANCE

Section 1. The City shall provide group hospitalization, surgical and dental insurance coverages or options to bargaining unit employees (except short-term temporary employees and those employed less than thirty (30) hours per week). A summary of insurance benefits that the City shall provide is set forth in Attachment A.

The premiums for such plan shall be paid as follows:

A. Effective through December 31, 2017, the City shall pay eighty-eight percent (88%) of the premium costs, and the bargaining unit member shall pay twelve percent (12%) of the premium costs through payroll deduction. Employees failing to satisfy the wellness program obligations (see, Attachment B) by September 1, 2016 will not be eligible for a "wellness" discount and will pay sixteen percent (16%) as their premium contribution for 2017. . In order to qualify for the reduced premiums in 2018 and 2019 the employee must satisfy the wellness components identified in Attachment B by September 1st of the preceding year.

B. Effective January 1, 2018, if the City's insurance premium costs increase by one percent (1%) or more, employees satisfying the wellness program obligations shall pay thirteen percent (13%) of the premium costs through payroll deduction. Employees failing to satisfy the wellness program obligations will not be eligible for a "wellness" discount and will pay seventeen percent (17%) as their premium contribution. The employee premium-contribution percentage shall remain at the 2017 percentage (12% or 16%) for 2018 if the City's insurance premium costs do not increase or increase by less than one percent (1%).

C. Effective January 1, 2019, if the City's insurance premium costs increase by one percent (1%) or more, employees satisfying the wellness program obligations shall pay a premium contribution one percent (1%) higher than the 2018 rate (an increase to either 13% or 14%) of the premium costs through payroll deduction. Employees failing to satisfy the wellness program obligations will not be eligible for a

"wellness" discount and will pay either seventeen percent (17%) (if the wellness rate is 13%) or eighteen percent (18%) (if the wellness rate is 14%) as their premium contribution. The employee premium contribution percentage shall remain at the 2018 percentage for 2019 if the City's insurance premium costs do not increase or increase by less than one percent (1%).

D. Newly-hired employees are not eligible for the reduced Wellness premium rate until the January 1st following successful completion of the September 1st to August 31st Wellness requirements.

Temporary full-time employees expected to be employed by the City for a continuous period greater than three (3) months shall be eligible for said benefit.

Section 2. The City retains the right, in its sole discretion, to change insurance carriers, provided the benefits and coverages under the policy with the new carrier are comparable to or better than the benefits and coverages provided to bargaining unit employees as of the effective date of this Agreement.

Section 3. Opt-out benefits set forth in the 2013-2016 Agreement shall be maintained through September 1, 2017. Effective September 1, 2017, employees who are eligible to receive family coverage under any comprehensive group medical plan who opt not to participate in such program and execute an appropriate waiver form, and who have met the wellness program obligations, will receive Four Hundred Twenty-Five Dollars ($425.00) per month in lieu of medical insurance coverage. Employees opting out of family coverage, who have not met the wellness program obligations, will receive Two Hundred Dollars ($200.00) per month in lieu of medical insurance coverage. For the period covering May 23, 2017 through August 31, 2017, pro-rated wellness-satisfaction requirements shall be identified by the City for those employees opting out who were not participating in the wellness program, in order for those employees to have an opportunity to satisfy the wellness obligations for September 1, 2017 through December 31, 2018. Failure to satisfy these pro-rated requirements will result in the employee receiving the reduced opt-out amount.

Section 4. Employees opting out who have successfully completed the wellness obligations of their spouse's healthcare plan can be considered as having satisfied the City's wellness obligations, provided that the City has approved the wellness criteria of the spouse's plan and confirmed the employee's satisfaction of same.

Section 5. The City and the OPBA mutually recognize that health care cost control is an important consideration and of mutual interest to both parties. The parties agree that the City's health care coverage and premium rates should be reviewed by an independent health care consultant. Accordingly, the City and OPBA agree to negotiate in good faith concerning health care cost control in the group hospitalization program provided by this Agreement at the end of the term of the Agreement.

Section 6. The City agrees that a representative of the bargaining unit shall participate in the study of health care coverage and premium cost issues with the City's Health Care Committee. Any agreed-upon resolution of healthcare program issues adopted by the Health Care Committee, and, in turn, approved by both the City and the Union, shall be incorporated into this Agreement.

(Ord. 187-02, 1-04, 42-07, 136-03, 131-08, 134-11, 97-14, 80-17)

NOW, THEREFORE, BE IT ORDAINED BY THE COUNCIL OF THE CITY OF MEDINA, OHIO:

SEC. 1: That Section 31.13 (2)(C) of the Salaries and Benefits Code of the City of Medina, Ohio shall be amended to read as follows pertaining to Vacation:

B. Basic Work Week. A basic work week as used in ~~Article 16~~. **Section 31.09.** **(Ord. 79-17, 130-17)**

SEC. 2: That Section 31.16 of the Salaries and Benefits Code of the City of Medina, Ohio shall be amended to read as follows pertaining to Group Hospitalization:

SECTION 31.16 GROUP HOSPITALIZATION INSURANCE

Section 1. The City shall provide group hospitalization, surgical and dental insurance coverages ~~or options~~ to **all full time employees, unless specified differently in union contracts.** ~~**bargaining unit employees (except short-term temporary employees and those employed less than thirty (30) hours per week).**~~ A summary of insurance benefits that the City shall provide is set forth in Attachment A. **(Ord. 187-02, 1-04, 42-07, 131-08, 134-11, 97-14, 80-17)**

The premiums for such plan shall be paid as follows:

A. Effective through December 31, 2017, the City shall pay eighty-eight percent (88%) of the premium costs, and the **employee** ~~**bargaining unit member**~~ shall pay twelve percent (12%) of the premium costs through payroll deduction. Employees failing to satisfy the wellness program obligations (see, Attachment B) by September 1, 2016 will not be eligible for a "wellness" discount and will pay sixteen percent (16%) as their premium contribution for 2017. . In order to qualify for the reduced premiums in 2018 and 2019 the employee must satisfy the wellness components identified in Attachment B by September 1st of the preceding year.

B. Effective January 1, 2018, if the City's insurance premium costs increase by one percent (1%) or more, employees satisfying the wellness program obligations shall pay thirteen percent (13%) of the premium costs through payroll deduction. Employees failing to satisfy the wellness program obligations will not be eligible for a "wellness" discount and will pay seventeen percent (17%) as their premium contribution. The employee premium-contribution percentage shall remain at the 2017 percentage (12% or 16%) for 2018 if the City's insurance premium costs do not increase or increase by less than one percent (1%).

C. Effective January 1, 2019, if the City's insurance premium costs increase by one percent (1%) or more, employees satisfying the wellness program obligations shall pay a premium contribution one percent (1%) higher than the 2018 rate (an increase to either 13% or 14%) of the premium costs through payroll deduction. Employees failing to satisfy the wellness program obligations will not be eligible for a "wellness" discount and will pay either seventeen percent (17%) (if the wellness rate is 13%) or eighteen percent (18%) (if the wellness rate is 14%) as their premium contribution. The employee premium contribution percentage shall remain at the

2018 percentage for 2019 if the City's insurance premium costs do not increase or increase by less than one percent (1%).

D. Newly-hired employees are not eligible for the reduced Wellness premium rate until the January 1st following successful completion of the September 1st to August 31st Wellness requirements.

E. **Healthcare coverage begins the first day of employment and ends on the last day of the last month during which an employee is employed by the City. (Ord. 42-07, 130-17)**

Temporary full-time employees expected to be employed by the City for a continuous period greater than three (3) months shall be eligible for said benefit.

Section 2. The City retains the right, in its sole discretion, to change insurance carriers, provided the benefits and coverages under the policy with the new carrier are comparable to or better than the benefits and coverages provided to bargaining unit employees as of the effective date of this Agreement.

Section 3. ~~**Opt-out benefits set forth in the 2013-2016 Agreement shall be maintained through September 1, 2017**~~. Effective September 1, 2017, employees who are eligible to receive family coverage under any comprehensive group medical plan who opt not to participate in such program and execute an appropriate waiver form, and who have met the wellness program obligations, will receive Four Hundred Twenty-Five Dollars ($425.00) per month in lieu of medical insurance coverage. Employees opting out of family coverage, who have not met the wellness program obligations, will receive Two Hundred Dollars ($200.00) per month in lieu of medical insurance coverage. For the period covering May 23, 2017 through August 31, 2017, pro-rated wellness-satisfaction requirements shall be identified by the City for those employees opting out who were not participating in the wellness program, in order for those employees to have an opportunity to satisfy the wellness obligations for September 1, 2017 through December 31, 2018. Failure to satisfy these pro-rated requirements will result in the employee receiving the reduced opt-out amount.

Section 4. Employees opting out who have successfully completed the wellness obligations of their spouse's healthcare plan can be considered as having satisfied the City's wellness obligations, provided that the City has approved the wellness criteria of the spouse's plan and confirmed the employee's satisfaction of same.

Section 5. **Effective November 1, 2003 employees who are eligible to receive the City's family group hospitalization insurance and elect to change, or who have previously changed from family to single coverage and execute an appropriate waiver form, will receive one hundred dollars ($100) per month in lieu of the family coverage. New employees, who are eligible to receive the City's family group hospitalization insurance and select single coverage instead of family and execute an appropriate waiver form, will receive one hundred dollars ($100) per month in lieu of family coverage. (Ord. 136-03, 130-17)**

~~**Section 5. The City and the OPBA mutually recognize that health care cost control is an important consideration and of mutual interest to both parties. The parties agree that the City's health care coverage and premium rates should be reviewed by an independent health care consultant. Accordingly, the City and OPBA agree to negotiate in good faith concerning**~~

~~health care cost control in the group hospitalization program provided by this Agreement at the end of the term of the Agreement.~~

~~Section 6.~~ ~~The City agrees that a representative of the bargaining unit shall participate in the study of health care coverage and premium cost issues with the City's Health Care Committee. Any agreed-upon resolution of healthcare program issues adopted by the Health Care Committee, and, in turn, approved by both the City and the Union, shall be incorporated into this Agreement~~.

(Ord. 187-02, 1-04, 42-07, 136-03, 131-08, 134-11, 97-14, 80-17, **130-17**))

ATTACHMENT B

THE CITY OF MEDINA
WELLNESS PROGRAM

To be eligible for the reduced premium contributions for 2018, 2019 and 2020 the employee must:

1. Complete an annual Health Risk Analysis by August 31, 2017; August 31, 2018 and August 31, 2019 to be administered by the wellness provider. The Health Risk Analysis is comprised of:
    a. A Health Risk Questionnaire, including height, weight, body mass index (BMI), waist circumference.
    b. Biometric screening in the form of a blood draw that will measure:
        i. Total Cholesterol
        ii. High-density lipoprotein (HDL)
        iii. Glucose
        iv. Low-density lipoprotein (LDL)
        v. Triglycerides
        vi. Blood pressure
2. Maintain an active account with a wellness provider designated by the City.
    a. Employees will need to log onto the website a minimum of 10 days per month and enter one or more entries each of those days. A minimum total of 10 days per month or 120 days per 12 months of logged entries must be entered in the following time frames: 09/01/2016-08/31/2017; 09/01/2017-08/31/2018; 09/01/2018-08/31/2019.
    b. This total will be gathered on an average, so if the employee misses logging on a specific month, although they will not be able to back log/back enter into a previous month once it has ended, they will be able to add additional entries in the current/future months to maintain their acceptable average. One activity per day, each month is the maximum credit they can earn towards the 120 annual amount.

3. Employee must attend or participate in three (3) Educational Activties during the following time frames: 09/01/2016-08/31/2017; 09/01/2017-08/31/2018, 09/01/2018-08/31/2019 – these can be a combination of any activities offered (need proof of participation).

Wellness program requirements may be subject to change based on the Healthcare Committee recommendations.

The parties agree, in concept, to the introduction of an outcomesbased component to the Wellness Program in 2018 for application to the 2019 rates. The parties agree to discuss the introduction of the outcomes-based component in the 2017 and 2018 Healthcare Committee meetings.

Wellness program design complies with Federal regulations. Program design may change as new regulations and / or clarifications are issued.
(Ord. 80-17)

SEC. 3: That it is found and determined that all formal actions of this Council concerning and relating to the passage of this Ordinance were adopted in an open meeting of this Council, and that all deliberations of this Council and any of its committees that resulted in such formal action, were in meetings open to the public, in compliance with the law.

SEC. 4: That this Ordinance shall be considered an emergency measure necessary for the immediate preservation of the public peace, health and safety; wherefore, this Ordinance shall be in full force and effect immediately upon its passage and signature by the Mayor.

PASSED: **September 11, 2017**

SIGNED: **John M. Coyne, III**
President of Council

ATTEST: **Kathy Patton**
Clerk of Council

APPROVED: **September 12, 2017**

SIGNED: **Dennis Hanwell**
Mayor

UnitedHealthcare

Choice Plus Plan AG3X / 0H9

Coverage Period: 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What This Plan Covers & What it Costs **Coverage for:** Employee & Family **Plan Type:** PS1

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at welcometouhc.com or by calling 1-800-377-5154.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $500 Individual / $1,000 Family Non-Network: $1,000 Individual / $2,000 Family Per calendar year. Copays, prescription drugs, and services listed below as "No Charge" do not apply to the deductible.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Network: $1,000 Individual / $2,000 Family Non-Network: $3,000 Individual / $6,000 Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of network providers, see myuhc.com or call 1-800-377-5154.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

Questions: Call 1-800-377-5154 or visit us at welcometouhc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy.

ATTACHMENT A

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31.16 Attachment A OED 130-17

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Coinsurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If a non-network provider charges more than the allowed amount, you may have to pay the difference. For example, if a non-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	40% co-ins after ded.	Virtual visits (Telehealth) – $20 copay per visit by a designated virtual network provider. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$40 copay per visit	40% co-ins after ded.	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$20 copay per visit	40% co-ins after ded.	Cost share applies to manipulative (chiropractic) services only and is limited to 15 visits per calendar year. Pre-authorization is required non-network or benefit reduces to the lesser of 50% of eligible expenses or $500.
	Preventive care / screening / immunization	No Charge	40% co-ins after ded.	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	40% co-ins after ded.	Pre-authorization is required non-network for sleep studies or benefit reduces to the lesser of 50% of eligible expenses or $500.
	Imaging (CT / PET scans, MRIs)	20% co-ins after ded.	40% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to the lesser of 50% of eligible expenses or $500.
If you need drugs to treat your illness or condition	Tier 1 – Your Lowest-Cost Option	Retail: $15 copay Mail-Order: $30 copay	Retail: $15 copay	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply Mail-Order: Up to a 90 day supply You may need to obtain certain drugs, including certain

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
More information about prescription drug coverage is available at myuhc.com	Tier 2 – Your Midrange-Cost Option	Retail: $30 copay Mail-Order: $60 copay	Retail: $30 copay	specialty drugs, from a pharmacy designated by us. Certain drugs may have a pre-authorization requirement or may result in a higher cost. If you use a non-network pharmacy (including a mail order pharmacy), you are responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Tier 1 contraceptives covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered.
	Tier 3 – Your Highest-Cost Option	Retail: $50 copay Mail Order: $100 copay	Retail: $50 copay	
	Tier 4 – Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-ins after ded.	40% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to the lesser of 50% of eligible expenses or $500.
	Physician / surgeon fees	20% co-ins after ded.	40% co-ins after ded.	None
If you need immediate medical attention	Emergency room services	$100 copay per visit	$100 copay per visit	None
	Emergency medical transportation	$50 copay per visit	$50 copay per visit	None
	Urgent care	$20 copay per visit	40% co-ins after ded.	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins after ded.	40% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to the lesser of 50% of eligible expenses or $500.
	Physician / surgeon fees	20% co-ins after ded.	40% co-ins after ded.	None
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	$20 copay per visit	40% co-ins after ded.	Partial hospitalization/intensive outpatient treatment: 20% coinsurance after deductible. Pre-authorization is required non-network for certain services or benefit reduces to the lesser of 50% of eligible expenses or $500. See your policy or plan document for additional information about EAP benefits.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Mental / Behavioral health inpatient services	20% co-ins after ded.	40% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to the lesser of 50% of eligible expenses or $500. See your policy or plan document for additional information about EAP benefits.
	Substance use disorder outpatient services	$20 copay per visit	40% co-ins after ded.	Partial hospitalization/intensive outpatient treatment: 20% coinsurance after deductible. Pre-authorization is required non-network for certain services or benefit reduces to the lesser of 50% of eligible expenses or $500. See your policy or plan document for additional information about EAP benefits.
	Substance use disorder inpatient services	20% co-ins after ded.	40% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to the lesser of 50% of eligible expenses or $500. See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Prenatal and postnatal care	No Charge	40% co-ins after ded.	Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	20% co-ins after ded.	40% co-ins after ded.	Inpatient pre-authorization may apply.
If you need help recovering or have other special health needs	Home health care	20% co-ins after ded.	40% co-ins after ded.	Limited to 60 visits per calendar year. Pre-authorization is required non-network or benefit reduces to the lesser of 50% of eligible expenses or $500.
	Rehabilitation services	$20 copay per outpatient visit	40% co-ins after ded.	Limits per calendar year: physical, speech, occupational – 30 visits; cardiac – 36 visits; pulmonary – 36 visits. Pre-authorization required for physical, occupational and speech non-network or benefit reduces to the lesser of 50% of eligible expenses or $500.
	Habilitative services	$20 copay per outpatient visit	40% co-ins after ded.	Limits are combined with Rehabilitation Services limits listed above. Pre-authorization is required non-network or benefit reduces to the lesser of 50% of eligible expenses or $500.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Skilled nursing care	20% co-ins after ded.	40% co-ins after ded.	Limited to 120 days per calendar year. (combined with inpatient rehabilitation). Pre-authorization is required non-network or benefit reduces to the lesser of 50% of eligible expenses or $500.
	Durable medical equipment	20% co-ins after ded.	40% co-ins after ded.	Pre-authorization is required non-network for DME over $1,000 or benefit reduces to the lesser of 50% of eligible expenses or $500. Covers 1 per type of DME (including repair/replacement) every 3 years.
	Hospice service	20% co-ins after ded.	40% co-ins after ded.	Inpatient pre-authorization is required for non-network or benefit reduces to the lesser of 50% of eligible expenses or $500.
If your child needs dental or eye care	Eye exam	$20 copay per outpatient visit	40% co-ins after ded.	Limited to 1 exam every 2 years
	Glasses	Not Covered	Not Covered	No coverage for glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult/Child)
- Glasses (Adult/Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids
- Routine eye care (Adult/Child)

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on the back of your ID card or at myuhc.com or Ohio Department of Insurance at 1-800-686-1526 or insurance.ohio.gov/Pages/default.aspx.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-377-5154.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-377-5154.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-377-5154.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-377-5154.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- Amount owed to providers: $7,540
- Plan pays $6,340
- Patient pays $1,200

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$500
Copays	$0
Coinsurance	$500
Limits or exclusions	$200
Total	$1,200

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- Amount owed to providers: $5,400
- Plan pays $4,360
- Patient pays $1,040

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Deductibles	$200
Copays	$800
Coinsurance	$0
Limits or exclusions	$40
Total	$1,040

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.
- If other than individual coverage, the Patient Pays amount may be more.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs), or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-377-5154 or visit us at welcometouhc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy.

ATTACHMENT B

THE CITY OF MEDINA
WELLNESS PROGRAM

To be eligible for the reduced premium contributions for 2018, 2019 and 2020 the employee must:

1. Complete an annual Health Risk Analysis by August 31, 2017; August 31, 2018 and August 31, 2019 to be administered by the wellness provider. The Health Risk Analysis is comprised of:
    a. A Health Risk Questionnaire, including height, weight, body mass index (BMI), waist circumference.
    b. Biometric screening in the form of a blood draw that will measure:
        i. Total Cholesterol
        ii. High-density lipoprotein (HDL)
        iii. Glucose
        iv. Low-density lipoprotein (LDL)
        v. Triglycerides
        vi. Blood pressure
2. Maintain an active account with a wellness provider designated by the City.
    a. Employees will need to log onto the website a minimum of 10 days per month and enter one or more entries each of those days. A minimum total of 10 days per month or 120 days per 12 months of logged entries must be entered in the following time frames: 09/01/2016-08/31/2017; 09/01/2017-08/31/2018; 09/01/201808/31/2019.
    b. This total will be gathered on an average, so if the employee misses logging on a specific month, although they will not be able to back log/back enter into a previous month once it has ended, they will be able to add additional entries in the current/future months to maintain their acceptable average. One activity per day, each month is the maximum credit they can earn towards the 120 annual amount.
3. Employee must attend or participate in three (3) Educational Activties during the following time frames: 09/01/2016-08/31/2017; 09/01/2017-08/31/2018, 09/01/201808/31/2019 – these can be a combination of any activities offered (need proof of participation).

Wellness program requirements may be subject to change based on the Healthcare Committee recommendations.

The parties agree, in concept, to the introduction of an outcomesbased component to the Wellness Program in 2018 for application to the 2019 rates. The parties agree to discuss the introduction of the outcomes-based component in the 2017 and 2018 Healthcare Committee meetings.

Wellness program design complies with Federal regulations. Program design may change as new regulations and / or clarifications are issued.
(Ord. 80-17)