ORDINANCE NO. 167-17

AN ORDINANCE AUTHORIZING THE MAYOR TO ENTER INTO A CONTRACT WITH MEDICAL MUTUAL OF OHIO FOR HEALTH CARE INSURANCE FOR THE EMPLOYEES OF THE CITY OF MEDINA, AND DECLARING AN EMERGENCY.

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

SEC. 1: That the Mayor is hereby authorized and directed to enter into a contract with Medical Mutual of Ohio to provide health care insurance for the employees of the City of Medina, Ohio for the year 2018.

SEC. 2: That a copy of the Contract is marked Exhibit A, attached hereto and incorporated herein.

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, and for the further reason so that employees may receive new insurance cards before the beginning of 2018; wherefore, this Ordinance shall be in full force and effect immediately upon its passage and signature by the Mayor.

PASSED: November 27, 2017

SIGNED: John M. Coyne, III
President of Council

ATTEST: Kathy Patton
Clerk of Council

APPROVED: November 28, 2017

SIGNED: Dennis Hanwell
Mayor

 OE0167-17

ClaimsLink[SM] Agreement (for Alliance Members)

Once the Agreement and Confidentiality Statements are completed, please return them to the appropriate Medical Mutual Account Representative.

This is a ClaimsLink[SM] Agreement ("the Agreement") between City of Medina (the "Group"), Group Number 778236 and Medical Mutual of Ohio ("Medical Mutual").

RECITALS

A. The Group is an insured member of an Alliance with which Medical Mutual has a signed agreement to provide group health plans to each member of the Alliance.

B. The Group has more than 100 eligible employees and desires to perform certain customer service and/or plan administration functions for those persons covered under group's health insurance plan (hereinafter the "Covered Person").

C. Medical Mutual has developed the ClaimsLink program to enable the Group to have access to certain claim and/or enrollment information via online access.

D. Medical Mutual and the Group wish to state their respective rights and responsibilities under the ClaimsLink program.

In consideration of the mutual promises contained herein, the parties agree as follows:

PROVISIONS

1. Medical Mutual will provide maintenance for and service to the online web application known as ClaimsLink.

2. The Group acknowledges that the ClaimsLink program will allow access only to information regarding the Group's Covered Persons.

3. The Group acknowledges that ClaimsLink will allow access to confidential medical and claim information on its Covered Persons. The Group represents and warrants that it has amended its Plan in compliance with HIPAA to allow it to receive PHI of its enrollees. Further, the Group agrees to keep confidential any medical and claim information it obtains regarding Covered Persons and will not divulge any claim information to any person or entity without the express written consent of Medical Mutual and the Covered Person. Notwithstanding the forgoing, the Group agrees that it will not disclose any information regarding the pricing or discount for any specific claims or providers. Such information is considered proprietary trade secret information of Medical Mutual.

The Group will be also given access to certain confidential and proprietary information of Medical Mutual in connection with the ClaimsLink program. The Group acknowledges that (i) Medical Mutual will make the information available to the Group solely for the purpose of the ClaimsLink program; (ii) Medical Mutual has a strong desire and legitimate interest in maintaining the confidentiality of the information; and (iii) the information is and will be made available to the Group in reliance on the Group's agreement to use the information solely for the purpose described in this ClaimsLink Agreement and in reliance on its agreement to keep the information strictly

confidential. The Group agrees that it will not disclose any information received from Medical Mutual without the prior written consent of Medical Mutual and shall not use or permit the use of any information except to the extent such disclosure or use is necessary to perform the customer service or membership functions for Covered Persons. The Group shall not make, use or permit making any copies, synopses or summaries of the information made available or supplied by Medical Mutual through the ClaimsLink program except to the extent necessary to perform customer service or membership functions for Covered Persons. The Group shall take all reasonable security precautions necessary to protect the information against unauthorized disclosure and to keep the information confidential including, but without limitation, protection of the information from theft, unauthorized duplication or discovery of the content.

4. As a public employer, the Group is subject to the laws of the State of Ohio, including without limitation the Ohio Constitution and applicable sections of the Ohio Revised Code. As such, (i) to the extent permitted by Ohio law, the Group agrees to be liable for the acts and omission of its officers, employees and agents engaged in the scope of their employment arising under this Agreement, and (ii) specifically, in lieu of the Group's obligation to indemnify Medical Mutual under this Agreement, the Group hereby agrees to be responsible for any and all liability, claims, costs, expenses (including reasonable legal fees) or damages arising from any claim with respect to the Group's actions in connection with this Agreement.

5. The Group agrees to instruct its employees that claim information may only be accessed on ClaimsLink in response to a specific inquiry from a Covered Person or as necessary to update enrollment or other membership information. The Group agrees that if it updates enrollment information using ClaimsLink it will pay its premiums as billed by Medical Mutual.

6. The Group agrees to adhere to proper security procedures and to allow access to ClaimsLink only by those employees who have been properly trained in its use and who have signed Confidentiality Statements (attached as Exhibit A) to keep information obtained from ClaimsLink strictly confidential. Each employee of the Group who has access to ClaimsLink must sign a Confidentiality Statement.

7. Medical Mutual makes no representations or warranties as to the accuracy or reliability of any conclusions or interpretations made by the Group or its employees from ClaimsLink information.

8. The ClaimsLink program and any materials related to the ClaimsLink program are the sole and exclusive property of Medical Mutual.

9. Medical Mutual reserves the right to alter, amend, modify, terminate or discontinue the ClaimsLink program and if necessary, to gain access to the ClaimsLink program at any time and without notice.

10. Medical Mutual reserves the right to withdraw or revoke without cause any consent or approval previously granted. Either party may terminate this ClaimsLink Agreement without cause by giving the other party (or the Agent of the other party) thirty (30) days advance written notice.

11. This Agreement shall be governed by Ohio law and any applicable federal law.

12. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors. The right to receive Confidential Information may not be assigned without Medical Mutual's written consent.

13. The effective date of this ClaimsLink Agreement is 1/1/2018 regardless of the date it is signed by the parties.

(SIGNATURES ON FOLLOWING PAGE)

IN WITNESS WHEREOF, the parties have signed this ClaimsLink Agreement on the dates indicated below.

City of Medina
GROUP NAME

Signature (Company Officer)

Dennis Hanwell
Name (type or print)

Mayor
Title

11-28-2017
Date

MEDICAL MUTUAL OF OHIO

Signature

Name (type or print)

Title

Date

EXHIBIT A
CONFIDENTIALITY STATEMENT

I have been advised and understand that Medical Mutual and the Alliance have a signed agreement pursuant to which Medical Mutual insures members of the Alliance. City of Medina (the "Group"), Group Number 778236 is an insured member of the Alliance. Medical Mutual has agreed to the provide the Group and/or its Agent with the ClaimsLink program that will enable the Group and/or its Agent to have access to certain claim information via online application to the Group and will allow the Group's or Agent's employees to perform customer service on behalf of Covered Persons. I further understand that Medical Mutual and the Group enforce a strong policy on the confidentiality of all medical claim records and that enforcement of the policy is essential to meet the needs of the Group's Covered Persons and is in accord with responsible business practices. For these reasons, I acknowledge the policy of confidentiality and agree to adhere to the following statement:

I am not to disclose to anyone other than a covered person, except to those who have signed similar Confidentiality Statements, nor am I to use in an improper manner any confidential information, including but not limited to, claims information, computer system information and medical information either during or after the term of the above-referenced agreement except with express written permission of Medical Mutual or the Covered Person(s). I agree not to access the ClaimsLink system except in response to a specific customer service inquiry. I agree only to disclose limited claim information to Covered Persons, and I am not to discuss or disclose specific diagnosis codes. Additionally, I will not disclose my password or allow any access to the ClaimsLink℠ system to any unauthorized person.

CLAIMSLINK OPTIONS REQUESTED

Required – Please check **only one** option:

- ✓ View claims and request replacement ID cards
- ___ View eligibility information ONLY
  NO claims access

OPTIONAL – Check only if applicable:

- ✓ Update, add, delete enrollment information.
  A fully insured group must agree to pay as billed.

SIGNED BY

[signature]
Signature (Company Employee)

Elizabeth Brown, Payroll Clerk
Print Name & Title

City of Medina
Company Name

132 N. Elmwood Ave
Company Address

ebrown@medinaoh.org
Email Address

Jennifer Hajdu — 24-2056
Sales Representative — Mail Zone

11-28-17
Date

ORD 167-17

ReportLink℠ Agreement for 100+ Alliance groups (Fully Insured Public Employer)
(11/2017)

MEDICAL MUTUAL SERVICES

ReportLink℠ Agreement (for Alliance Members)

Once the Agreement and Confidentiality Statements are completed, please return them to the appropriate Medical Mutual Account Representative.

This is a ReportLink Agreement ("Agreement") between City of Medina (the "Group"), Group Number 778236 and Medical Mutual of Ohio ("Medical Mutual").

RECITALS

A. The Group is an insured member of an Alliance with which Medical Mutual has a signed agreement to provide group health plans to each member of the Alliance.

B. The Group has more than 100 eligible employees and desires to perform certain administrative and/or analytical functions using its claims data.

C. Medical Mutual has developed the ReportLink Internet application to enable the Group to have access to certain claim information.

D. Medical Mutual and the Group wish to set out their respective rights and responsibilities under the ReportLink application.

In consideration of the mutual promises contained herein, the parties agree as follows:

PROVISIONS

1. Medical Mutual will provide maintenance for and service to the online web application.

2. The Group acknowledges that the ReportLink application will allow access only to information regarding the Group.

3. The Group acknowledges that ReportLink will allow access to confidential medical and claim information on its Covered Persons. The Group represents that it has amended its Plan in compliance with HIPAA to allow it to receive PHI of its enrollees. Further, the Group agrees to keep confidential any medical and claim information it obtains regarding Covered Persons and will not divulge any claim information to any person or entity without the express written consent of Medical Mutual and the Covered Person. Notwithstanding the forgoing, the Group agrees that it will not disclose any information regarding the pricing or discount for any specific claims or providers. Such information is considered proprietary trade secret information of Medical Mutual.

4. As a public employer, the Group is subject to the laws of the State of Ohio, including without limitation the Ohio Constitution and applicable sections of the Ohio Revised Code. As such, (i) to the extent permitted by Ohio law, the Group agrees to be liable for the acts and omission of its officers, employees and agents engaged in the scope of their employment arising under this Agreement, and (ii) specifically, in lieu of the Group's obligation to indemnify Medical Mutual under this Agreement, the Group hereby agrees to be responsible for any and all liability, claims, costs, expenses (including reasonable legal fees) or damages arising from any claim with respect to the Group's actions in connection with this Agreement.

5. The Group agrees to instruct its employees that claim information may only be accessed on ReportLink to prepare reports regarding claims experience that is necessary to the administration of the Plan.

6. The Group agrees to adhere to proper security procedures and to allow access to ReportLink only by those employees who have been properly trained in its use and who have signed Confidentiality Statements (attached as Exhibit A) to keep information obtained from ReportLink strictly confidential. Each employee of the Group who has access to ReportLink must sign a Confidentiality Statement.

7. Medical Mutual makes no representations or warranties as to the accuracy or reliability of any conclusions or interpretations made by the Group, its agents or its employees from ReportLink information.

8. The ReportLink application and any materials related to the ReportLink application are the sole and exclusive property of Medical Mutual.

9. Medical Mutual reserves the right to alter, amend, modify, terminate or discontinue the ReportLink application, and if necessary to gain access to the ReportLink application at any time and without notice.

10. Medical Mutual reserves the right to withdraw or revoke without cause any consent or approval previously granted. Either party may terminate this ReportLink Agreement without cause by giving the other party thirty (30) days advance written notice.

11. This agreement shall be governed by Ohio law & any applicable federal law.

12. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors. The right to receive Confidential Information may not be assigned without Medical Mutual's written consent.

13. The effective date of this ReportLink Addendum is January 1, 2018 regardless of the date it is signed by the parties.

IN WITNESS WHEREOF, the parties have signed this ReportLink Agreement on the dates indicated below.

Group City of Medina	**Medical Mutual of Ohio**
D C Hanwell	
Signature (Company Officer)	Signature
Dennis Hanwell	
Name (type or print)	Name (type or print)
Mayor	
Title	Title
November 28, 2017	
Date	Date

ReportLink[SM] Agreement for 100+ Alliance groups (Fully Insured Public Employer)
(11/2017)

EXHIBIT A
CONFIDENTIALITY STATEMENT

I have been advised and understand that Medical Mutual and the Alliance have a signed agreement pursuant to which Medical Mutual insures members of the Alliance. City of Medina (the "Group"), Group Number 778236 is an insured member of the Alliance. Medical Mutual has agreed to provide the Group with the ReportLink application that will enable the Group to have access to certain claim information via the internet. I further understand that Medical Mutual and the Group enforce a strong policy on the confidentiality of all medical claim records and that enforcement of the policy is essential to meet the needs of the Group's Covered Persons and is in accord with responsible business practices. For these reasons, I acknowledge the policy of confidentiality and agree to adhere to the following statement:

I am not to disclose to anyone, except to those who have signed similar Confidentiality Statements, nor am I to use in an improper manner any confidential information, including but not limited to, claims information, computer system information and medical information either during or after the term of the above-referenced agreement except with express written permission of Medical Mutual or the Covered Person(s) or as permitted by the HIPAA privacy rules. I will not, under any circumstances, disclose any information regarding the amount of Medical Mutual's payment to providers. I agree not to access the ReportLink application except in response to a specific reporting need. I agree only to disclose limited claim information to third parties, and I am not to discuss or disclose specific diagnosis codes. Additionally, I will not disclose my password or allow any access to the ReportLink application to any unauthorized person.

SIGNED BY

Elizabeth Brown
Signature (Company Employee)

Elizabeth Brown, Payroll Clerk
Print Name & Title

City of Medina
Company Name

132 N. Elmwood Ave.
Company Address

330 722 9055
Company Phone

ebrown@medina oh.org
Email Address

Jennifer Hajdu — 24-2056
Sales Representative — Mail Zone

11-28-17
Date

REPORTLINK OPTIONS REQUESTED

Please check the appropriate box:

✓ Fully Insured Group

___ Both Fully Insured and Self-Funded (mixed)
If funding is mixed, the sales representative for the Group must contact Reporting and Data Management to set up the proper ReportLink structure.

Please check the desired access for this individual:
✓ ReportLink Reports
___ Self Insured Invoices
___ Both

Ord. 167-17

Greater Akron Chamber

Employer Group Enrollment Application/Change Form
For Groups with 51-500 Eligible Employees

Medical Mutual®

☒ initial enrollment ☐ change

Consumers Life® A Medical Mutual Company

1. Group/Company Information

Business Name: City of Medina				
Has this business ever been known by another name? ☐Yes ☒No If yes, what name(s)?				Medical Mutual Membership # (if applicable)
Business Address (No P.O. Boxes): 132 N. Elmwood Avenue			Billing Address	
City: Medina	County: Medina	State: OH	Zip Code: 44256	Business Phone Number: 330-725-7777
Chief Executive Officer: Dennis Hanwell	Billing Contact			Business Fax Number
Business E-Mail	Number of years in business (If less than one year specify the date the business started.)			Plan Year: 2018
Type of Business (be specific): Government	SIC Code			Employer/Federal Tax ID #: 34-6001856

Has group ever applied with Medical Mutual? ☒ Yes ☐ No If so, when? mmo has on file

Is plan grandfathered? ☐ Yes ☒ No

Is the plan subject to ERISA? ☒ Yes ☐ No (Check the applicable box below)

- ☒ Government entity (i.e., city, county, township, public school district)
- ☐ Church plan
- ☐ Group of one (self employed)
- ☐ Other: _____

Do you have any affiliations with other companies or unions (include parent, subsidiary, joint venture, etc...) ?

☐ Yes ☒ No If yes, please describe. —

If yes, do any of these affiliates qualify as a single employer under subsection (b), (c), (m), or (o) of the Internal Revenue Code Section 414? If yes, please give the legal names, federal tax ID# and number of employees.

—

Order Number: X9475 2/15
Dept of Ins. Filing Number: X9076 R7/14

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2. Enrollment Criteria

Eligible Employee Definition: What is the minimum # of hours to be worked per week for employees to be considered eligible for insurance benefits* 30 hours

Per ACA guidelines, your group probationary period may not exceed 90 calendar days. Therefore, eligible members electing coverage shall be effective no later than their 91st calendar day of employment.

- ☒ Date of Hire
- ☐ First of month following Date of Hire
- ☐ 30 calendar days following Date of Hire
- ☐ First of month following 30 calendar days
- ☐ 60 calendar days following Date of Hire
- ☐ First of month following 60 calendar days
- ☐ 90 calendar days following Date of Hire
- ☐ Other (not to exceed 90 calendar days from Date of Hire _____

Waive probationary period for initial enrollment? ☐ Yes ☐ No

* Minimum cannot be greater than 30 hours per week for groups with 51 or more eligible employees.
**Including owners, officers and partners who receive compensation from the company, reported on a tax form other than a 1099.

Are there any other employer imposed eligibility requirements? ☐ Yes ☒ No
If "yes", explain: _____

Employer Contributions (Check box and specify amount)

	Single	2-Person	Family	Retiree
	☒ $ 776.38	☐ $ _____	☒ $ 1942.20	☐ $ _____
or	Single	Spouse	Child (per # children)	Retiree
	☐ $ _____	☐ $ _____	☐ $ _____	☐ $ _____

Participation ☒ Census was provided	Active**	COBRA	Retired**
Total number of current employees (part time & full time)			
Total number of full-time equivalents			
Total number of eligible employees			
Number of eligible employees applying for coverage			
Total number of ineligible employees			
Total number of waivers			

Provide details below for anyone currently eligible or enrolled in COBRA.

Name	Social Security #	Beginning Date	Expiration Date	Qualifying Event

Provide details below for any retirees who meet the eligibility requirements AND are members of a formal retirement program?

Name	Social Security #	Age at Retrmnt	Date of Retrmnt	Date of Hire	Avg. Hrs. Worked Per Week Prior to Retrmnt
n/a					

Order Number: X9475 2/15
Dept of Ins. Filing Number: X9075 R7/14

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3. Recent Health Changes

Are you aware of any medical conditions present for enrolling members that may not yet have been disclosed to Medical Mutual during the past 90 days? ☐ Yes ☒ No

If yes, please describe ———

4. Employer Funding

Is any part of the employee's or dependent's deductible being funded by the employer or from an employer-established account? ☐ Yes ☒ No If so, how much? Single: _____ Family: _____

Does the employer fund first? ☐ Yes ☒ No

Order Number: X9476 2/15
Dept of Ins. Filing Number: X9076 R7/14

MEDICAL MUTUAL

N/A

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5. Life, AD&D, Dependent Life and Short-Term Disability

☐ Yes I am electing life and/or short-term disability coverage in accordance with proposal number _____, incorporated by reference in and made part of this application for all purposes.
If multiple plans are indicated on the proposal, indicate plan option elected _____.

The requested effective date will be as stated in the above-mentioned proposal, unless indicated below:

_____.

If the Company approves this application, a policy will be issued. The applicant agrees that acceptance of the Policy will be approval of the Policy terms.

Participation-free coverage
☐ Yes, I am electing participation-free Voluntary Life and AD&D
☐ Yes, I am electing participation-free Voluntary Life, AD&D and short-term disability.
If participation-free, voluntary short-term disability is elected, indicate the plan: _ 1/8/13 _ 1/8/26

Waiting period is identical to medical probationary period, unless indicated below:
☐ None
☐ First of month following completion of _____ days
☐ Other _____

Employees working less than 20 hours per week are not eligible for coverage. If different than 20 hours, please indicate number of hours:_____

Employer contribution percentages (%) for all products are stated in the proposal, unless indicated below:

Product	%	Product	%
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Group Long-Term Disability

☐ Yes I am electing group long-term disability coverage in accordance with proposal number _____, incorporated by reference in and made part of this application for all purposes.
If multiple plans are indicated on the proposal, indicate plan option elected _____.

The requested effective date will be as stated in the above-mentioned proposal, unless indicated below:

_____.

If the Company approves this application, a policy will be issued. The applicant agrees that acceptance of the Policy will be approval of the Policy terms.

Prior carrier: _____
(Prior carrier must be listed and a copy of the prior policy included for continuity of coverage to apply.)

Termination date of prior policy: _____

Waiting period – present employees: _____

Waiting period – future employees: _____

Employees working less than 30 hours per week are not eligible for coverage. If different than 30 hours, please indicate number of hours: _____.

Contribution:
Employer _____% Employee _____% ☐ Pre-tax dollars ☐ Post-tax dollars

Order Number: X9475 2/15
Dept of Ins. Filing Number: X9025 (07/14

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6. Terms and Conditions

I, as the undersigned employer or other eligible membership organization duly organized under the laws of the State of Ohio, hereby apply to the carrier(s) offering the coverage indicated on this Application. I acknowledge that by applying for these products, coverage is provided by the following entities (collectively referred to as "Medical Mutual"):

- Medical Mutual of Ohio® (MMO) for non-HMO health plans
- Medical Health Insuring Corporation of Ohio (MHICO) for HMO health plans
- Consumers Life Insurance Company® (CLIC) for life, accidental death and dismemberment, and disability benefits

I understand, acknowledge and agree to the following:

- **This Employer Group Enrollment Application and Change Form ("Application") is not a contract for benefits. I should continue my current coverage until I am notified in writing that Medical Mutual has accepted this Application.**
- If this Application is accepted by Medical Mutual, the actual benefits will be specified in the group contract(s) and that said benefits will take effect on the date specified in a communication from the applicable carrier(s) underwriting my group coverage.
- For all groups, each employee not enrolling must complete the waiver section of the applicable employee application.
- Only my full-time employees are eligible for coverage. All individuals who apply for insurance coverage from Medical Mutual must be full-time, common-law employees, drawing a regular paycheck, whose compensation is reported on IRS Form W-2. Independent contractors are not eligible for coverage. For life and/or disability benefits only, being Actively at Work (as described earlier in this Application and defined in the group policy) is a requirement for coverage. If an employee is not Actively at Work on the day his coverage would otherwise be effective, the effective date of his life and/or disability coverage will be the date of his return to Active Work. If an employee does not return to Active Work, he will not be covered.
- To be eligible for coverage, I must comply with all applicable laws of the State of Ohio. By applying for coverage, I agree that Medical Mutual may, from time to time, verify my compliance with the underwriting eligibility or participation standards of the pertinent program. I agree to provide payroll records if requested by Medical Mutual or any other carrier to verify my compliance.
- Any untrue or incomplete information, statements or answers on this Application (whether or not intentional) or engaging in any fraudulent conduct, deceptions or misrepresentation relating to any application, coverage, claim or usage of a carrier identification card, can result in denial of a claim or rescission of coverage for me or any group member, and may subject me or any group member to legal action by Medical Mutual. I have a duty to notify Medical Mutual of any changes to the information contained in this Application.
- Approval and acceptance of this Application and individual employee applications are subject to Medical Mutual's underwriting guidelines, as permitted by law. Checking the boxes does not cause automatic enrollment. Medical Mutual must approve this Application.
- This Application shall be made part of the policy for which application is made and supersedes any previous applications for this group coverage.
- By signing this Application, I represent that this group or company is not an entity that has been formed primarily to obtain insurance coverage, and it does not permit membership in this group or company solely for the purpose of obtaining insurance coverage.
- I authorize Medical Mutual to obtain information from prior carriers to determine existence of pre-existing conditions. Prior carriers are authorized to release such information to Medical Mutual upon receipt of a copy of this Application. Medical Mutual collects this data as a service to you.

Continued on page 6

Order Number: X9475 2/15
Dept of Ins. Filing Number: X9075 R7/14

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6. Terms and Conditions (continued)

- No agent or broker has the authority to: (1) bind Medical Mutual by making promises regarding eligibility, benefits, or the issuance of a policy; (2) waive any answer or any portion of any answer to any question on this Application or any information Medical Mutual requests; (3) approve coverage; (4) make or alter any contract on behalf of Medical Mutual; or (5) waive or alter any of Medical Mutual's other rights or requirements. All contract terms must be in writing and signed or accepted in writing by an authorized representative of Medical Mutual to be binding on Medical Mutual.

- The group or company hereby appoints the Secretary of Medical Mutual of Ohio as its proxy, with power of substitution, to act for and on its behalf at any and every annual meeting or any special meeting of the members of Medical Mutual of Ohio. The group or company authorizes its proxy to vote and act for and on behalf of the member at such meeting as fully and to the same extent as the member could do if present thereat. This proxy shall continue in force until ten years from the date hereof unless sooner revoked by a notice in writing signed by the group and delivered to Medical Mutual of Ohio.

7. Authorized Signature (Please print)

Business Name: City of Medina	Name (print): Dennis Hanwell	Title: Mayor
Authorized Signature: Dennis Hanwell 11-28-17		Date: 11-20-17
Broker Signature (if applicable):	Broker Name (print) (if applicable): Dino Scalli DS Benefits Group	
Commissions Payable to Federal Tax ID #: 26-3218911	Royal Advantage Broker	

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

Order Number: X9475 2/15
Dept of Ins. Filing Number: X9075 R7/14

MEDICAL MUTUAL®

HIPAA Privacy Certification

Whereas, Medical Mutual of Ohio ("Health Plan") has entered into an agreement to provide health insurance for City of Medina ("Plan Sponsor") dated 01/01/2018.

Whereas, the Health Insurance Portability and Accountability Act of 1996 (CFR 160 and 164) Privacy regulation ("HIPAA") requires that Health Plans obtain a certification from the Plan Sponsor that states that the Plan Sponsor has amended its Plan Document and agrees to certain restrictions.

Whereas, the Health Plan may not share Protected Health Information with the Plan Sponsor without the certification.

Now, therefore, the Plan Sponsor certifies:

I. Plan Sponsor has amended its Plan Document to contain the following:
   1. Establish the permitted and required uses and disclosures of such information by the Plan Sponsor, and such uses and disclosures are consistent with the provisions of HIPAA.
   2. Describe those employees or classes of employees or other persons under the control of the plan sponsor to be given access to the Protected Health Information to be disclosed, provided that any employee or person who receives Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the group health plan in the ordinary course of business must be included in such description.
   3. Restrict the access to and use by such employees and other persons described in paragraph 164.504(f)(2)(iii)(A) to the plan administration functions that the plan sponsor performs for the group health plan.
   4. Provide an effective mechanism for resolving any issues of noncompliance by persons described in paragraph 164.504(f)(2)(iii)(A) of this section with the plan document provisions required by this paragraph.

II. Plan Sponsor agrees to:
   1. Not use or further disclose the information other than as permitted or required by the plan documents or as required by law.
   2. Ensure that any agents, including a subcontractor, to whom it provides protected health information received from the group health plan agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information.

3. Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.
4. Report to the group health plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.
5. Make available protected health information in accordance with § 164.524.
6. Make available protected health information for amendment and incorporate any amendments to protected health information in accordance with §164.526.
7. Make available the information required to provide an accounting of disclosures in accordance with § 164.528.
8. Make its internal practices, books and records relating to the use and disclosure of protected health information received from the group health plan available to the Secretary of Health and Human Services or his/her designee for purposes of determining compliance by the group health plan with this subpart.
9. If feasible, return or destroy all protected health information received from the group health plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
10. Ensure that the adequate separation required in paragraph 164.504(f)(2)(iii) is established.

This HIPAA Privacy Certification may be exchanged by facsimile or other electronic means, each of which shall be deemed to be an original. The parties hereto agree and stipulate that the original of this HIPAA Privacy Certification, including the signature page, may be scanned and stored in a computer database or similar device, and that any printout or other output readable by sight, the reproduction of which reproduces the original of this document, may be used for any purpose just as if it were the original, including proof of the content of the original writing.

ACKNOWLEDGED AND AGREED TO

D R Hanwell

Signature

Dennis Hanwell, Mayor

Title

11-28-2017

Date

MEDICAL MUTUAL OF OHIO
AND ITS FAMILY OF COMPANIES

GRANDFATHERED STATUS FORM
51+ size groups

Group Name: City of Medina
Group Number: 778236

Date Submitted: 11/16/2017
Submitted by: Char Klimczak

Effective Date: 01/01/2018

Total number of Employees
Total number of Employees eligible for coverage

A. Non Grandfathered – Please determine whether the plan sponsor has made any of the following changes to the company's healthcare plan:

Please check the applicable box in Part 1 and then move to Part 2

Part 1

- ☐ The company decreased its level of contribution to health premiums by more than 5 percent below the contribution rate on March 23, 2010, for any tier of coverage and any class of similarly situated individuals
- ☐ The company merged, acquired or engaged in a similar business restructuring and the main purpose of the action is to cover new individuals under the grandfathered plan
- ☐ The company eliminated a benefit option and transferred employees to another benefit option (please contact your broker for futher guidance)
- ☐ The company's health plan includes a health reimbursement account (HRA) and the company changed the level of contribution in a manner that increased the amount the covered person must contribute to the deductible
- ☐ The plan increased copayments by an amount that exceeds the greater of the sum of medical inflation plus 15 percent or $5 adjusted annually by medical inflation
- ☐ The plan increased the employee's cost-sharing percentage requirements (e.g., coinsurance)
- ☐ The plan increased the fixed-amount, cost-sharing requirements (e.g., deductible, out-of-pocket limits), other than copayments, in a manner that exceeds the sum of medical inflation plus 15 percent
- ☐ The plan substantially eliminated benefits to diagnose or treat a particular condition (e.g., maternity)
- ☐ The plan added an overall annual limit on the dollar value that is lower than the dollar value of the former lifetime limit
- ☐ The plan added an overall annual limit on the dollar value of benefits if the plan was not imposing an overall annual or lifetime limit on the dollar value of benefits
- ☐ If the plan imposed an overall annual limit on the dollar value of all benefits, the plan decreased the dollar value of the overall annual limit (regardless of whether the plan had an overall lifetime limit)
- ☐ Other ____

Part 2

Please check the applicable box and then move to Part 3 for signature

- ☒ I represent my entire group is losing its grandfathered status **or**
- ☒ I represent the following sections are losing grandfathered status-Sections

Part 3

Group Official Signature: Dennis Harwell
Mayor Dennis Harwell

Date: 11-28-17

B. Grandfathered

Please check the applicable box in Part 1 and then move to Part 2

Part 1

- ☐ None of the items above in Section A apply to my group or certain sections of my group and grandfathered status is maintained
- ☐ Self-funded group selected third-party administrator with no reduction in benefits or contribution and grandfathered status is maintained

Part 2

Please check one of the following boxes and then move to Part 3

- ☐ I represent my group is maintaining its grandfathered status
- ☐ I represent the following sections are maintaining grandfathered status-Sections
- ☐ I represent the following base group or sections will lose their grandfathered status-Sections

C. Grandfathered and Non-grandfathered groups

Please check all of the applicable boxes and then proceed to signature

☐ I represent I have provided the required documentation (such as documentation of contribution stating the group's contribution as of March 23, 2010, plus current contribution requirements, a schedule of benefits, certificate of coverage, summary plan document or benefit highlight sheet) of the plan terms from the prior health coverage sufficient to determine that the plan has not changed in a manner that will cause it to lose grandfather status. The provided documents verify the following:

- ☐ Benefits
- ☐ Cost Sharing
- ☐ Employer Contributions
- ☐ Annual Limits

Group Official Signature: _____ **Date:** ____