RESOLUTION NO. 19 , 2010

A RESOLUTION AUTHORIZING THE CITY MANAGER TO ENTER INTO A CONTRACT WITH MEDICAL MUTUAL OF OHIO TO PROVIDE MEDICAL COVERAGE FOR FULL-TIME EMPLOYEES

WHEREAS, the City of Montgomery provides health insurance benefits to its full-time employees; and

WHEREAS, the City has requested and reviewed proposals for health insurance benefits and determined that the proposal submitted by Medical Mutual of Ohio is the best proposal for City employees in terms of quality, price, service and adaptability.

NOW THEREFORE BE IT RESOLVED by the Council of the City of Montgomery, Ohio:

SECTION 1. The City Manager is hereby authorized to enter into a contract with Medical Mutual of Ohio to provide health insurance benefits for all full-time employees for one year commencing September 1, 2010 through August 31, 2011, subject to any separate requirements from any Collective Bargaining Agreement between the City and any employee group during the term of this benefit contract.

SECTION 2. The City Manager is hereby authorized to pay Medical Mutual of Ohio according to the rates set forth in the schedule submitted by Medical Mutual of Ohio attached hereto as Exhibit "A" and incorporated herein by reference.

SECTION 3. This Resolution shall be in full force and effect from and after its passage.

PASSED: August 4, 2010

ATTEST: Susan J. Hamm
Susan J. Hamm, Clerk of Council

Gerri Harbison
Gerri Harbison, Mayor

APPROVED AS TO FORM
Terrence M. Donnellon
Terrence M. Donnellon, Law Director

City of Montgomery

7.7.10 Rate Revised Rates, Contingent on Life Insurance offered

September 1, 2010 Renewal

		Current			Renewal				$3000 Deductible			
		Medical Mutual Of SuperMed Plus HSA $2500 ded	Medical Mutual Of Ohio Super Med Plus $1000 ded 80%/$25 OV 10/35/55 Drugs		Medical Mutual Of SM Plus HSA $2500 Ded		Medical Mutual Of Ohio SM Plus $1000 ded 80%, Rx 10/35/55		Medical Mutual Of SM Plus HSA $2500 Ded		Medical Mutual Of Ohio SM Plus $1000 ded 80%, Rx 10/35/55	
Rates	**Counts**											
Employee Only	18	$300.87	0	$395.57	18	$376.21	0	$500.28	18	$352.70	0	$500.28
Employee + Spouse	13	$601.73	0	$802.89	13	$752.40	0	$1,015.24	13	$705.36	0	$1,015.24
Employee + Child(ren)	7	$571.64	0	$763.05	7	$714.78	0	$964.86	7	$670.10	0	$964.86
Family	26	$859.61	0	$1,146.91	26	$1,074.86	0	$1,450.25	26	$1,007.66	0	$1,450.25
Combined Est. Monthly Premium		$39,589.49			$49,502.80				$46,408.14			
Combined Est. Annual Premium		$475,073.88			$594,033.60				$556,897.68			
Percentage Change From Current		0%			25.04%				17.20%			
Annual Dollar Change From Current		$0.00			$118,959.72				$81,823.80			
Benefits		In-Network		In-Network	In-Network		In-Network		In-Network		In-Network	
Deductible												
Calendar Year or Policy Year?		Policy year		Policy Year	Policy year		Policy Year		Policy year		Policy Year	
Individual/Family		$2500/$5000		$1000/$2000	$2500/$5000		$1000/$2000		$3000/$6000		$1000/$2000	
Coinsurance		100/0		80/20	100/0		80/20		100/0		80/20	
Out-of-Pocket Maximum												
Deductible Included?		Yes		Yes	Yes		Yes		Yes		Yes	
Individual/Family		$2500/$5000		$2500/$5000	$2500/$5000		$2500/$5000		$3000/$6000		$2500/$5000	
Lifetime Maximum		$5,000,000		$5,000,000	$5,000,000		$5,000,000		$5,000,000		$5,000,000	
Inpatient Hospital												
Facility		Ded,100/0		Ded, 80/20	Ded,100/0		Ded, 80/20		Ded,100/0		Ded, 80/20	
Physician		Ded,100/0		Ded, 80/20	Ded,100/0		Ded, 80/20		Ded,100/0		Ded, 80/20	
Outpatient												
Facility		Ded,100/0		Ded, 80/20	Ded,100/0		Ded, 80/20		Ded,100/0		Ded, 80/20	
Physician		Ded,100/0		Ded, 80/20	Ded,100/0		Ded, 80/20		Ded,100/0		Ded, 80/20	
Labs												
Routine Lab		Covered in full		100% for Professional Provider; ded., then 80%/20% for Facility Provider	Covered in full		100% for Professional Provider; ded., then 80%/20% for Facility Provider		Covered in full		100% for Professional Provider; ded., then 80%/20% for Facility Provider	
Diagnostic Lab		Ded,100/0		100% for Professional Provider; ded., then 80%/20% for Facility Provider	Ded,100/0		100% for Professional Provider; ded., then 80%/20% for Facility Provider		Ded,100/0		100% for Professional Provider; ded., then 80%/20% for Facility Provider	
Emergency Room		Ded,100/0		$100 Copay	Ded,100/0		$100 Copay		Ded,100/0		$100 Copay	
Urgent Care		Ded,100/0		$50 Copay	Ded,100/0		$50 Copay		Ded,100/0		$50 Copay	
Office Visit												
Primary Care/Specialist Visit		Ded,100/0		$25 Copay	Ded,100/0		$25 Copay		Ded,100/0		$25 Copay	
Wellness		Covered in full		$25 Copay	Covered in full		$25 Copay		Covered in full		$25 Copay	
Vision		Covered in full		$25 Copay	Covered in full		$25 Copay		Covered in full		$25 Copay	
Prescription Drugs												
Deductible		Same as medical		none	Same as medical		none		Same as medical		none	
Tier 1/Tier 2/Tier 3/Tier 4		Ded,100/0		$10/$35/$55	Ded,100/0		$10/$35/$55		Ded,100/0		$10/$35/$55	
Mail-Order		Ded,100/0		$20/$87.50/$137.50	Ded,100/0		$20/$87.50/$137.50		Ded,100/0		$20/$87.50/$137.50	