

A RESOLUTION AUTHORIZING THE MAYOR AND THE FINANCE DIRECTOR TO ENTER INTO AN AGREEMENT WITH UNITED HEALTHCARE FOR UNITED HEALTHCARE PPO 200 CHOICE PLAN HEALTH INSURANCE FOR VILLAGE EMPLOYEES AND DECLARING AN EMERGENCY


WHEREAS, the Village's insurance advisor has recommended entering into an agreement with United Healthcare to be the provider for health insurance for Village employees during the year 2004.

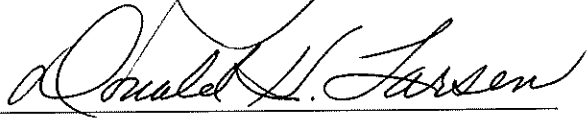
NOW, THEREFORE, BE IT RESOLVED by the Council of the Village of Richfield, Summit County, State of Ohio:

SECTION 1. That the Mayor and the Finance Director be, and they hereby are, authorized and directed to enter into an agreement with United Healthcare PPO 200 Choice Plan for the Village's health insurance effective January 1, 2004, in accordance with the letter from Dettling Associates, the Village's employee benefits consultant, dated December 1, 2003, a copy of which letter is attached hereto as Exhibit "A" and incorporated herein fully as if by reference.

SECTION 2. This Resolution is hereby declared to be an emergency measure necessary for the immediate preservation of the public health, safety and welfare and for the further reason that it is immediately necessary in order to be effective January 1, 2004; wherefore, provided this Resolution receives the affirmative vote of two-thirds of the members of Council elected or appointed, it shall take effect immediately upon its passage and execution by the Mayor; otherwise, it shall take effect and be in force from and after the earliest period allowed by law.


PASSED: December 16, 2003


President of Council


Mayor

Dated: 12/23/2003

ATTEST:


Clerk of Council



-Employee Benefit Consultants-

3291 Stanley Road
Akron, Ohio 44333-9203

Thomas R. Dettling
Principal
Dettling Associates
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December 10, 2003

Ms. Eleanor Lukovics, Finance Director
Village of Richfield
4410 W. Streetsboro Road
P. O. Box 387
Richfield, Ohio 44286-0387

RE: United Healthcare's PPO 200 Choice Plus

Dear Eleanor:

The following are your rates for the above program that will be effective January 1, 2004. Also, enclosed is a copy of the program.

CLASS	RATE
Employee	\$303.18
Employee + Spouse	\$636.68
Employee + Child(ren)	\$576.05
Employee + Family	\$909.55

Above rates are 12.81% higher than present rates.

Sincerely,

Thomas R. Dettling

✓
cc: ELMO, MIDDLEY

PPO F (Plan 00200)

PLAN PROVISION	NETWORK BENEFITS	NON-NETWORK BENEFITS
NOTE: All annual benefit limits are based on a Calendar year.	Services received from network providers	Services received from non-network providers
Deductible The amount you pay each year before the Plan begins covering your medical expenses. All non-network services are subject to the deductible unless otherwise stated.	Individual - \$250 Family - \$500	Individual - \$500 Family - \$1,000
Out-of-Pocket Maximum Total amount you pay in a year for deductible, coinsurance and copayments.	Individual - \$1,250 Family - \$2,500 Copays for all covered services apply to the out-of-pocket maximum except: office visits, mental health services, substance abuse services, and urgent care services.	Individual - \$2,500 Family - \$5,000
Maximum Policy Benefit	Unlimited	\$1 million
FEATURE/SERVICE	NETWORK MEMBER PAYS	NON-NETWORK MEMBER PAYS
Physician Office Services Office visits for sickness and injury	\$15 per visit*	30% of Eligible Expenses
Well Baby/Child Care Including immunizations and injections	\$15 per visit*	30% of Eligible Expenses Limited to \$500 per child to age 1; thereafter \$150
Routine Vision Exams Refractive eye exams limited to one per Calendar year.	\$15 per visit*	30% of Eligible Expenses Preventative care services other than well child care limited to \$100 per Calendar year.
Comprehensive Physical Exams	\$15 per visit *	30% of Eligible Expenses Preventative care services other than well child care limited to \$100 per Calendar year.
Obstetrical office visits (pre- and post natal)	\$15 per visit* (Initial visit to confirm the pregnancy requires office copay.)	30% of Eligible Expenses
Allergy Services Testing, serum, injections, venoms	10% of Eligible Expenses	30% of Eligible Expenses
Professional Fees for Surgical and Medical Services	10% of Eligible Expenses	30% of Eligible Expenses
Inpatient Hospital Services	10% of Eligible Expenses	30% of Eligible Expenses

*Not subject to the deductible.

FEATURE/SERVICE	NETWORK MEMBER PAYS	NON-NETWORK MEMBER PAYS
Emergency Care Coverage applies for a serious medical condition resulting from injury or sickness which arises suddenly and requires immediate care to avoid jeopardy to life or health.	\$100 per visit	Covered as a Network benefit
Ambulance Services Emergency transport to nearest hospital	10% of Eligible Expenses	Covered as a Network benefit
Urgent Care Services Health Services provided at an Urgent Care Center	\$35 per visit*	30% of Eligible Expenses
Outpatient Hospital and Alternate Facility Services <ul style="list-style-type: none"> • Lab and X-ray • Facility charges for outpatient surgery 	10% of Eligible Expenses	30% of Eligible Expenses
Mental Health and Substance Abuse Services <ul style="list-style-type: none"> • Outpatient Mental Health Services • Inpatient Mental Health Services • Inpatient and Outpatient Substance Abuse Services 	Network services must be provided or authorized by a mental health/substance abuse designee. \$20 per individual visit; \$10 per group.* Limited to 30 visits per Calendar year. 10% of Eligible Expenses Limited to 30 days per Calendar year. Copays are the same as mental health services and benefits are limited to \$550 for inpatient services and \$550 for outpatient services per Calendar year.	30% of Eligible Expenses. Limited to 10 visits per Calendar year. 30% of Eligible Expenses. Limited to 10 days per Calendar year. 30% of Eligible Expenses. Limited to \$550 per Calendar year
Skilled Nursing Facility Services Limited to 180 days per Calendar year	10% of Eligible Expenses	30% of Eligible Expenses. Limited to 60 days per Calendar year
Prosthetic Devices and Durable Medical Equipment	10% of Eligible Expenses	30% of Eligible Expenses
Outpatient Rehabilitation Services Physical, Speech, Occupational and Cardiac Rehabilitation Therapy. Limited to 20 visits per each therapy type.	\$15 per visit when performed at a physician's office.* 10% of Eligible Expenses for Health Services provided at a Network facility	30% of Eligible Expenses
Spinal Manipulation Limited to \$250 per Calendar year	Not covered	30% of Eligible Expenses*
Hospice Limited to 180 days during the period of time a Covered Person is covered under the policy.	10% of Eligible Expenses.	50% of Eligible Expenses

***Not subject to the deductible.**

This Summary of Benefits is intended only to highlight your benefits and should not be relied upon to fully determine coverage. This plan may not cover all your health care expenses. Please refer to your Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the policies issued to the enrolling group, the policies prevail.

When you enroll with United HealthCare of Ohio, Inc. (United HealthCare), you can obtain covered medications through our convenient, easy to use prescription drug program.

How Does the Coverage Work?

To be eligible for coverage under the network pharmacy benefit, your prescription must be:

- Written by a United HealthCare network physician; and
- Filled at a network pharmacy or through the designated mail service pharmacy program.

Your copay depends upon the type of drug you receive. Network pharmacies will dispense U.S. Food and Drug Administration approved generic drugs unless you or the prescribing physician request a brand-name drug.

Pharmacy Network

United HealthCare has contracted with approximately 30,000 pharmacies nationwide so you'll probably find your local pharmacy in our network. Refer to a United HealthCare Provider Listing or Directory for a complete list of network pharmacies near your home or work.

This summary is intended to highlight your prescription drug benefits and should not be relied upon to fully determine coverage. Please refer to your Certificate of Coverage for a complete list of covered services, limitations, exclusions and a description of all terms and conditions of coverage. Certain drugs require prior authorization by United HealthCare of Ohio to be eligible for coverage.

Plan 95810

Pharmacy Copays

Present your United HealthCare identification card at any network pharmacy and pay your copay (listed below). No claims forms are needed.

For a single copay, you can obtain up to a 31-day supply of most medications (unless limited by manufacturer's packaging) or one cycle of oral contraceptives:

- | | |
|---|------|
| • Generic drugs | \$10 |
| • Brand-name drugs on the Preferred Drug List | \$25 |
| • Drugs not on the Preferred Drug List | \$45 |

Mail Order Copays

You can also obtain prescription medications through United HealthCare of Ohio's designated mail service pharmacy program.

Simply pay the mail order copay (shown below), and you can obtain up to a 90-day supply of a prescription medication, three cycles of oral contraceptives, and diabetic supplies including insulin, diabetic test strips and syringes with needles.

- | | |
|---|----------|
| • Generic drugs | \$25 |
| • Brand-name drugs on the Preferred Drug List | \$62.50 |
| • Drugs not on the Preferred Drug List | \$112.50 |

Partial List of Exclusions and Limitations

- Experimental, investigational or unproven services and medications
- Any prescription drug or product dispensed for the purpose of appetite suppression or weight loss or smoking cessation
- Over-the-counter drugs that do not require a prescription order or refill and any drug therapeutically equivalent to an over-the-counter drug
- Replacement drugs resulting from a stolen, lost, broken or destroyed prescription order or refill
- General and injectable vitamins, including B-12 injections
- Prescription drugs to treat infertility
- Prescriptions from dentists or from non-network providers

**COMPARISON OF UNITED HEALTHCARE'S
2003 PROGRAM WITH 2004 PROGRAM
FOR THE VILLAGE OF RICHFIELD**

	<u>UNITED HEALTHCARE</u> 2003	<u>UNITED HEALTHCARE</u> 2003	<u>UNITED HEALTHCARE</u> 2004	<u>UNITED HEALTHCARE</u> 2004
ITEM:	Plus/525 Choice Plus	Plus/525 Choice Plus	PPO 200 Choice Plus	PPO 200 Choice Plus
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Physician's Visits:	\$15 Co-pay	20% after Deductible*	\$15 Co-pay	30% after Deductible*
Lab & X-ray:	In Full	20% after Deductible*	10% after Deductible*	30% after Deductible*
In-Patient Hospital:	In Full	20% after Deductible*	10% after Deductible*	30% after Deductible*
Out Patient Surgery Charge:	In Full	20% after Deductible*	10% after Deductible*	30% after Deductible*
In-Hospital Emergency Room:	\$50 Co-pay	\$50 Co-pay	\$100 Co-pay	\$100 Co-pay
Ambulance:	20% Co-pay	20% Co-pay	10% after Deductible*	10% after Deductible*
		* \$200 Deductible	* \$250 Deductible	* \$500 Deductible
Maximum Out-of-Pocket:	\$500/\$1,000	\$1,000/\$2,000	\$1,250/\$2,500	\$2,500/\$5,000
<u>Prescription Drugs:</u>				
Generic	\$7 Co-pay	\$7 Co-pay	\$10 Co-pay	\$10 Co-pay
Name Brand	\$20 Co-pay	\$20 Co-pay	\$25 Co-pay	\$25 Co-pay
Non-Formulary	\$40 Co-pay 2-1/2x Mail Order Available 90 Days	\$40 Co-pay 2 1/2x Mail Order Available 90 Days	\$45 Co-pay 2x Mail Order Available 90 Days	\$45 Co-pay 2x Mail Order Available 90 Days
Dependents:	Birth to Age 19; 19-25, if Student	Birth to Age 19; 19-25, if Student	Birth to Age 19; 19-25, if Student	Birth to Age 19; 19-25, if Student

2004 rates adjusted 12.81% for Plan PPO 200. Your contributions will remain the same.

VILLAGE OF RICHFIELD