2018 RUSSELL TOWNSHIP
MEDICAL COSTS and BUDGETS
CONSIDERATIONS

THE MOVING PARTS		
1		**PREMIUMS**
	1.0	EMPLOYEE HEALTHCARE CONTRIBUTION (CURRENTLY @ 15% OF HEALTHCARE)
	1.1	EMPLOYEE OTHER CONTRIBUTIONS (CURRENTLY @ 0% OF DENTAL, VISION, & LIFE)
	1.2	PREMIUM INCREASES ARE OFTEN ONLY CONSIDERED IN COST ANALYSIS
	1.3	PREMIUM EFFECT ON EMPLOYEES
2		**DEDUCTIBLES**
	2.0	IN NETWORK VS. OUT OF NETWORK DEDUCTIBLE FUNDING
	2.1	MAXIMUM OUT OF POCKET CONSIDERATIONS
	2.2	DEDUCTIBLE EFFECT ON EMPLOYEES
3		**CO-INSURANCE (CO-PAYS)**
	3.0	OUT OF NETWORK RATIOS
	3.1	MAXIMUM OUT OF POCKET CONSIDERATIONS
	3.2	CO-INSURANCE EFFECT ON EMPLOYEES
	3.3	EFFECTS OF NETWORK BOUND PLANS
4		**NETWORK VS. NON-NETWORK**
	4.0	NETWORK BOUND PLANS INCREASE RESERVE REQUIREMENTS
	4.1	MAXIMUM OUT OF POCKET CONSIDERATIONS
	4.2	IN NETWORK PROVIDERS CAN CHANGE
	4.3	NETWORK VS. NON-NETWORK EFFECT ON EMPLOYEES
5		**EMBEDDED VS. AGGREGATE**
	5.0	AGGREGATE PLANS COULD INCREASE DEDUCTIBLE ACTUARIES
	5.1	PLAN CHANGES FROM EMBEDDED TO AGGREGATE CAN HIDE INCREASES

2018 RUSSELL TOWNSHIP
MEDICAL COSTS and BUDGETS
SUMMARY

CURRENT HEALTHCARE		
1		BENOVATION
2		OPEC CONSORTIUM (COG BASED)
3		PRE-EVENT APPROVAL CONCEPT
4		NO NETWORK (NO OUT OF NETWORK; 100% COVERAGE AFTER $2,500/$5,000 DEDUCTIBLE)
5		NO CO-INSURANCE - 100% COVERAGE AFTER DEDUCTIBLE
6		MAX OUT OF POCKET = DEDUCTIBLE
7		EMBEDDED DEDUCTIBLE PROGRAM (SEE EXAMPLE)
8		15% CURRENT PREMIUM SHARING WITH EMPLOYEES
9		0% CURRENT DEDUCTIBLE SHARING WITH EMPLOYEES
RECOMMEND CLEARCHAIN HEALTHCARE - OPTION A (SUBJECT TO APA APPROVAL)		
1		PHI - NEAR IDENTICAL COVERAGE AS CURRENT PROVIDER
2		PHI CONSORTIUM (COG BASED)
3		PRE-EVENT APPROVAL CONCEPT
4		NO NETWORK (NO OUT OF NETWORK; 100% COVERAGE AFTER $2,500/$5,000 DEDUCTIBLE)
5		NO CO-INSURANCE - 100% COVERAGE AFTER DEDUCTIBLE
6		MAX OUT OF POCKET = DEDUCTIBLE
7		AGGREGATE DEDUCTIBLE PROGRAM (SEE EXAMPLE)
8		15% CURRENT PREMIUM SHARING WITH EMPLOYEES, INCREASE TO 17.5%
9		0% DEDUCTIBLE SHARING WITH EMPLOYEES
RECOMMEND BACKUP MEDICAL MUTUAL HEALTHCARE - OPTION B		
1		RETURN TO TRADITIONAL INSURANCE MODEL AS BEFORE BENOVATION
2		MMO BASED
3		POST-EVENT AGREED PAYMENT CONCEPT
4		NETWORK ($2,500/$5,000; OUT OF NETWORK = $3,000/$6,000 W/ 40/60% CO-INSURANCE AND $7,500/$15,000 MAX OUT OF POCKET)
5		CO-INSURANCE OUT OF NETWORK 40/60%
6		MAX OUT OF POCKET = $2,500/$5,000 IN NETWORK; $7,500/$15,000 OUT OF NETWORK
7		EMBEDDED DEDUCTIBLE PROGRAM (SEE EXAMPLE)
8		15% CURRENT PREMIUM SHARING WITH EMPLOYEES, INCREASE TO 17.5%
9		0% DEDUCTIBLE SHARING WITH EMPLOYEES
RECOMMEND DENTAL CARE PLUS DENTAL		
1		EXACTLY MATCHES CURRENT PLAN OFFERING WITH DELTA DENTAL
2		REDUCED PREMIUM OF APPROXIMATELY 5.4%
3		MAKE PART OF EMPLOYEE CONTRIBUTION COVERAGE
	3.1	0% CURRENT PREMIUM SHARING WITH EMPLOYEES, INCREASE TO 17.5%
RECOMMEND OPEC-VSP VISION		
1		CONTINUATION OF CURRENT PLAN THROUGH 12/31/2018
2		NO CHANGE IN PREMIUM
3		MAKE PART OF EMPLOYEE CONTRIBUTION COVERAGE
	3.1	0% CURRENT PREMIUM SHARING WITH EMPLOYEES, INCREASE TO 17.5%
RECOMMENDED STANDARD LIFE		
1		CONTINUATION OF CURRENT PLAN THROUGH 12/31/2018
2		NO CHANGE IN PREMIUM
3		MAKE PART OF EMPLOYEE CONTRIBUTION COVERAGE
	3.1	0% CURRENT PREMIUM SHARING WITH EMPLOYEES, INCREASE TO 17.5%

www.russelltownship.us
Phone: 440-338-7783
Fax: 440-338-1965

December 14, 2017

Outstanding Medical Claims Update

As per your request, I have reviewed the claims and bills that Russell Township employees have submitted to me for reconciliation with the insurance companies. To date, I have received 48 challenged claims from employees that were either billed to them as the employees responsibility, were listed as outstanding in an explanation of benefits, or were brought to the employees attention by the doctor/facility visited as outstanding. Of these outstanding bills, 22 were denied by Medical Mutual, yet fell under the period when we were still covered by Medical Mutual Insurance (prior to July 1, 2017). Medical Mutual refused to pay these claims and sent the message "Your employer's self funded benefit plan has failed to provide Medical Mutual with funds from which to pay the claims."

Additionally, one employee received a bill for an outstanding claim indicating it was the patient's responsibility under Benovation's insurance, and another employee was billed under Benovation due to not receiving prior approval before visiting a specialist, but it was resolved in the same day.

15 of the outstanding claims were billed erroneously to the wrong insurance on file from the doctor's office/hospital and I have asked that our OPEC representative resubmit these claims to the correct insurance. The remaining claims did not have indication of which insurance was billed or why it was the patient responsibility and are still being reconciled.

Thank you,

Brittany L. Milite
Assistant to the Fiscal Officer

PUBLIC healthcare
+ INITIATIVE

November 30, 2017

Dear Group Official:

We appreciate the opportunity to introduce the Public Healthcare Initiative (PHI) to your group. Employer provided benefits such as medical, dental, life, and vision programs are a foremost concern for the employees of public entities. Attracting and retaining the most valuable employees is the driving force behind any group's employee benefit offering. Programs offered through PHI will demonstrate a commitment to quality, transparency, innovation, and overall value that is uncommon in today's market. Selecting the best benefits for your group's employees and families, while being fiscally responsible can be challenging. Thanks for letting us help during this process.

Waypoint Benefit Solutions has helped the Public Healthcare Intiative to offer a healthcare program that delivers true value to the membership. The ClearChain program demonstrates a transparent and innovative approach to enable your memers to have access to the right care, at the right place, for the right price. In this proposal, you will find a comparison between your current plan, and what's available to your group through the Public Healthcare Initiative.

We truly value the opportunity to present this option to your group, please reach out with any questions and we will be here to help.

Sincerely,

Brian P. Savage
Co-Founder
Waypoint Benefit Solutions

Megan M. Toitch
Co-Founder
Waypoint Benefit Solutions

Russell Township in Geauga County

Benefit Level	Current OPEC-HC 2017	Proposed ClearChain 2018
Deductible	$2,500 / 5,000 (Embedded)	$2,500 / 5,000 (Aggregate)
Co-Insurance	100%	100%
Out-of-pocket	$2,500 / 5,000	$2,500 / 5,000
Primary Care Provider Co-Pay	Ded. Then 100%	Ded. Then 100%
Specialist Co-Pay	Ded. Then 100%	Ded. Then 100%
Urgent Care Co-Pay	Ded. Then 100%	Ded. Then 100%
Emergency Room Co-Pay	Ded. Then 100%	Ded. Then 100%
Prescription Co-Pays (30 day supply)	Ded. Then 100%	Ded. Then 100%
Mail Order Prescription Co-Pays (90 day supply)	Ded. Then 100%	Ded. Then 100%

Coverage Type	Count	Rates 2017	Rates 2018
Employee Only	5	$544.55	$544.55
Employee & Spouse	6	$1,086.54	$1,086.54
Employee & Child(ren)	2	$893.34	$893.34
Family	13	$1,441.26	$1,441.26
TOTAL	**26**	**$29,765.05**	**$29,765.05**

This form is intended as a quick comparison of benefit levels and rates. Rates are proposed for 1/1/2018 and are limited to Public Healthcare intitiative (PHI) members. Rates demonstrate pricing based off of a minimum PHI enrollment.
Signed proposal must be received by 12/22/2017 for a 1/1/2018 effective date.

X

Authorized Signature, Title ***Date***

Please submit this form to Waypoint Benefit Solutions Attn: Andrea Moore
amoore@waypointbenefits.com
Or fax to (614) 467-3610

Russell Township in Geauga County

Benefit Level	Current OPEC-HC 2017	Proposed ClearChain 2018
Deductible	$2,500 / 5,000 (Embedded)	$2,500 / 5,000 (Aggregate)
Co-Insurance	100%	100%
Out-of-pocket	$2,500 / 5,000	$2,500 / 5,000
Primary Care Provider Co-Pay	Ded. Then 100%	Ded. Then 100%
Specialist Co-Pay	Ded. Then 100%	Ded. Then 100%
Urgent Care Co-Pay	Ded. Then 100%	Ded. Then 100%
Emergency Room Co-Pay	Ded. Then 100%	Ded. Then 100%
Prescription Co-Pays (30 day supply)	Ded. Then 100%	Ded. Then 100%
Mail Order Prescription Co-Pays (90 day supply)	Ded. Then 100%	Ded. Then 100%

Coverage Type	Count	Rates 2017	2018
Employee Only	4	$544.55	$544.55
Employee & Spouse	5	$1,086.54	$1,086.54
Employee & Child	1	$718.95	$718.95
Employee & 2 Children	1	$893.34	$893.34
Employee & 3+ Children	0	$1,137.46	$1,137.46
Family & 1 Child	4	$1,263.91	$1,263.91
Family & 2 Children	6	$1,441.26	$1,441.26
Family & 3+ Children	4	$1,686.79	$1,686.79
TOTAL	**25**	**$29,673.55**	**$29,673.55**

This form is intended as a quick comparison of benefit levels and rates. Rates are proposed for 1/1/2018 and are limited to Public Healthcare intitiative (PHI) members. Rates demonstrate pricing based off of a minimum PHI enrollment.

X

Authorized Signature, Title *Date*

Please submit this form to Waypoint Benefit Solutions Attn: Andrea Moore
amoore@waypointbenefits.com
Or fax to (614) 467-3610

DRAFT
Dated: 12/14/17

BYLAWS OF THE
PUBLIC HEALTH CARE INITIATIVE BENEFIT COUNCIL

These Bylaws set forth the rights and responsibilities of the Public Health Care Initiative Benefit Council and its respective Members. Terms used but not defined herein shall have the meaning set forth in Ohio Revised Code Chapter 167 or the Member Agreement.

I. Purpose. The Council ("Council" or "PHI") is established to promote cooperative agreements between subdivisions of government, including counties, cities, villages, townships, school districts, joint and building districts, and other special districts and authorities. In particular, Council was created to provide healthcare benefits to its Members' employees.

II. Authority of Council.

(a) Consistent with Ohio Revised Code Section 167.03, Council shall have the power to:

i. Study such area governmental problems common to two or more of its Members including matters related to their health, safety, welfare, education, economic conditions and regional development;

ii. Promote cooperative arrangements and coordinate action among its Members, between its Members and other agencies of local or state governments and the federal government;

iii. Make recommendations for review and action to the Members and other public agencies that perform functions within the region;

iv. Promote cooperative agreements and contracts among its Members or other governmental agencies and private persons, corporations, or agencies;

v. Operate a public safety answering point in accordance with Chapter 128 of the Revised Code;

vi. Perform planning directly by personnel of the Council or under contracts between the Council and other public or private planning agencies.

III. Membership.

(a) Eligibility. Any qualified public employee or political subdivision may apply for Council Membership. The Board of Directors shall have sole discretion to determine

1) management and the oversight of the operations of Council;

2) determine all appropriate insurance coverages, including amounts, for the Plan, Program and PHI, which includes considering, reviewing and obtaining prudent amounts of Reinsurance to maintain the financial health of PHI should unpredictable events occur that might otherwise jeopardize the ongoing operations of the Program;

3) adopt policies and procedures to ensure the confidentiality of any individually identifiable medical information of a Covered Person, including but not limited to protected health information under HIPAA;

4) determine or cause to be determined the total estimated Program Costs for the Program for each Fiscal Year and determine the percentage of the total estimated and actual Program Costs to be allocated to each Member;

5) enter into contracts as necessary to conduct and operate PHI and the Program;

6) establish all rules regarding the payment of funds from PHI;

7) determine and retain, and oversee, the services or employment of any consultants or professionals necessary for the administration, improvement, growth or management of the Program, Plan or PHI, including actuaries and preferred vendor organizations (PVO);

8) change any Plan Document(s) and the Program with respect to the coverage and types of benefits of Covered Persons;

9) determine the fees and other consideration to be paid to any PVO, consultant or professionals retained in connection with the Program, Plan or PHI;

10) set and approve the amount of fidelity bond, if any, to be maintained by any PVO;

11) make minor or ministerial changes to or modification of the Program so as to make the administration and management of the Program more efficient or effective;

12) receive Member contributions and manage the Program Fund;

13) admit Members to PHI;

14) disqualify Members from PHI;

15) make an annual budget of PHI;

(k) Electronic Transaction of Business. To the fullest extent permitted by law, the Board of Directors and any committee thereof may conduct business, including giving any notice, attending or participating in meetings, giving a copy of any document or transmitting any writing, or voting, by authorized communications equipment as permitted under Ohio Revised Code Chapter 1702.

(l) Board Member's Limited Liability. Neither the Board nor its individual members shall be liable for any action taken or omitted in good faith, or for any action taken or omitted by any individual, firm, corporation, or any other organization selected with reasonable care, or any other act or omission made in compliance with its duties to the Plan. Liability Insurance covering the Board may be purchased as an authorized expenditure PHI.

V. **Program Funding**.

(a) Estimate of Costs. The Board shall set annual estimated costs for each Member, which shall include:

(i) Program Costs for the following Fiscal Year;

(ii) Each Member's respective share of the Program Costs, including and Assessments or estimates thereof;

(iii) Claims contingency reserves; and

(iv) Incurred but not reported claims.

Bi-annual reviews of the Program shall also be performed of any Member deficit so any necessary adjustments to Program Costs or Assessments can be made as necessary.

Each Member's share of Program Costs shall be the sum of the costs allocated to each Member by the Board as set forth below. The Board may utilize the services of an outside consultant to assist in its preparation of the following estimates:

(b) The Board (after consultation with the PVO) shall determine the amount of funds necessary to pay the claims of Covered Persons of each Member for the next Fiscal Year by evaluating: (a) the claims experience for that Member's Covered Person's for any preceding year and the amounts which that Member is obligated to pay for claims, less any amount subject to reimbursement by reinsurance available to PHI; (b) allowances which may be made for increased costs or utilization of benefits; (c) changes, if any, in the number or ages of Covered Persons for that Member; (d) changes, if any, to the amount of reserves to be held in the Reserve Fund of each Member; (e) changes, if any, in the types of claims covered by the Program; (f) incurred, but not reported, claims; or (g) any other matters which the Board deems relevant to such determination.

(c) The Board shall determine the estimated costs of all fees, any administrative expenses, fees to be paid to all other parties, including but not limited to CMS, consultants or

in that notice. Such additional Program Costs shall be apportioned among the Members in the same proportion as the Program Costs for that Fiscal Year were apportioned, unless otherwise directed by the Board.

VI. Conflict of Interest.

(a) Definitions. "Designated Person" means any Director, any member of a committee of the Corporation that is authorized to approve transactions or assert claims on behalf of the Corporation, any officer of the Corporation, and any employee or agent of the Corporation who is authorized to approve transactions or assert claims on behalf of the Corporation ("Designated Persons"). A Designated Person has a "Conflict of Interest" with respect to an agreement, arrangement or transaction effected or proposed to be effected by the Corporation or an entity controlled by the Corporation (a "Transaction") or a claim, action, cause of action, right or defense of the Corporation or entity controlled by the Corporation (a "Claim") if the Designated Person knows that any person or entity other than the Corporation (including but not limited to the Designated Person) has a financial interest in or related to the Transaction or Claim that would reasonably be expected to exert an influence on the Designated Person's judgment if he or she were called upon to authorize or vote upon the authorization of the Transaction or the assertion of the Claim. Notwithstanding the foregoing, a Designated Person does not have a Conflict of Interest with respect to a Transaction or Claim solely because it may affect the amount of compensation of the Designated Person under an existing incentive compensation program if the program was previously approved by the Board and the Designated Person did not participate in the deliberations or voting concerning the program. A competitor of the Corporation or of an entity controlled by the Corporation is deemed to have a financial interest in any Transaction or Claim if a decision one way or the other concerning the Transaction or Claim would reasonably be expected to adversely affect the competitor's business.

(b) Reporting. A Designated Person who has a Conflict of Interest shall disclose the Conflict of Interest when it arises, and before action on the Transaction or Claim in question. Disclosure is required even if a decision concerning the Transaction or Claim is not subject to approval by the Designated Person or the Board or committee on which the Designated Person serves. Conflicts of Interest involving the Chair or any Director shall be reported to the Board, and Conflicts of Interest concerning other Designated Persons shall be reported to the Chair, in which case the Chair will make the Conflict of Interest known to the Board and any applicable committee at the next regularly scheduled meeting. The minutes of the Board and of any committee at which a Conflict of Interest was reported shall state who was present for any discussions and votes concerning the Transaction or Claim involving the Conflict of Interest. The reporting requirements of this Section 2 do not apply to any direct compensation agreement or arrangement between the Corporation and a Designated Person.

(c) Effect of Conflict of Interest. A Designated Person who has a Conflict of Interest arising out of or related to a Transaction or Claim shall be excused from the meeting before any deliberations or voting concerning the authorization of the Transaction or the assertion of the Claim, provided that the Designated Person shall make the disclosure required by this provision, respond to questions from the Board or committee, and be counted in determining the presence of a quorum at any meeting of the Board or committee. Any Transaction involving a Conflict of Interest

DRAFT

Dated: 12/14/17

PUBLIC HEALTHCARE INITIATIVE BENEFIT PROGRAM MEMBER AGREEMENT

NOW THEREFORE, is agreed to by the undersigned that:

AGREEMENT

ARTICLE I
GENERAL

1.01 Recitals. Member has read and understood the foregoing recitals and acknowledges that they are correct, truthful and accurate.

1.02 Member Authority. Member represents and warrants that by signing the below, its authorized representative has obtained and adopted all necessary approvals and resolutions to enter into and execute this Agreement and join the PHI.

1.03 Member Acknowledgements. Member understands and acknowledges that by signing this Agreement:

(i) it agrees to become a Member of PHI, and it is subject to and bound by the Bylaws of the PHI; and

(ii) it is jointly and severally liable for the claims and all other associated costs including Program Costs, of all members electing to participate in PHI; and

(iii) it intends and authorizes PHI, in its sole discretion, to seek and retain a consulting, marketing and servicing firm to enroll new members in PHI; and

(iv) PHI shall administer and pay benefits under the Programs; and

(v) it is solely responsible for compliance with benefits laws and neither PHI, nor the CMS, shall be responsible for Member's compliance responsibility nor for any civil damages or administrative penalties which may be assessed against Member for any non-compliance with federal or state benefits laws.

ARTICLE II
DEFINITIONS

2.01 Definitions. As used in this Agreement, the following words shall have the following meanings:

(i) "Actuary" shall mean a person who is a member of the Society of Actuaries, or similar organization, or a firm of actuaries, at least one of whom is such an enrolled actuary and a member of the Society of Actuaries or similar organization.

name, has paid the Program Costs due, and has not withdrawn from or been terminated from PHI.

(xii) "PHI" shall mean the regional council of governments, organized under Chapter 167 of the Ohio Revised Code or other applicable law, consisting of eligible political subdivisions (including but not limited to a regional council of governments, a governmental trust, or a joint self-insurance program otherwise permitted by law, which may become Members pursuant to this Agreement).

(xiii) "Plan" shall mean the specific medical, hospitalization, dental, vision, life, disability income, and/or prescription drug benefits provided to each Member, as initially selected by each Member and as may be subsequently modified by the Board.

(xiv) "Plan Document" shall mean the document of a Member describing eligibility for, and the benefits available to Covered Persons of that Member under the Program.

(xv) "Political Subdivision" when used herein shall have the same meaning as given to it by Chapter 167 and Section 9.833 of the Ohio Revised Code.

(xvi) "Preferred Vendor Organization" or "PVO" shall mean any organization having contracted with multiple vendors who have agreed to facilitate healthcare services favorably or at reduced rates to PHI.

(xvii) "Program Costs" shall mean all costs determined by PHI hereof and any other costs incurred in connection with the operation of Program and approved by the Board.

(xviii) "Reserve Amount" shall mean that amount PHI must have in the Fund to pay the maximum amount of claims that could be filed by Covered Persons at any given time during a Fiscal Year that would not be covered by stop-loss insurance.

(xix) "Surplus Funds" shall mean the amounts in the Fund for any given Fiscal Year that exceeds all of the Program Costs.

(xx) "Term" shall mean the period of time that a Member has agreed to participate in the Program honor the terms of this Agreement.

ARTICLE III
MEMBERS

3.01 Term of Agreement. The Term of this Agreement shall be at least one Contract Year and shall renew automatically for additional Contract Years unless terminated under Article VIII. Except as otherwise expressly and specifically provided herein, during the Term, each Member shall be and remain liable and responsible for meeting any and all of the its duties, obligations, liabilities, and responsibilities under this Agreement and by virtue of being part of

(xi) That neither CMS nor the PHI assumes any responsibility to provide any specified level of benefit, benefits provisions, type of coverage, or amount of allowable payment, in order to meet the requirements of Member's collective bargaining agreements or satisfy the outcome of any employee or bargaining group member dispute or grievance. PHI reserves the right to withdraw plan offerings or change benefit levels at any time; and

(xii) That is jointly and severally liable with all other members for the Program Costs, which include but are not limited to the healthcare claims of all Members and the administrative expenses of PHI; and

(xiii) To acknowledge that healthcare costs, and in turn, the Program Costs, are inherently unpredictable and may exceed any estimate of costs provided by PHI or CMS to any Member at any time; and

(xiv) To be bound by the terms and conditions of all service and administrative agreements that PHI enters into on behalf of members.

ARTICLE IV
BENEFITS

4.01 Benefit Coverage. PHI shall administer the provision of medical, hospitalization, dental, prescription drug, vision, life, disability income, or any other benefits that may be included, from time to time, in a Plan Document, to all Covered Persons of each Member for all claims incurred during membership in PHI. Insurance limits, types of claims covered, eligibility for benefits and any deductibles shall be approved by the governing board of each Member and shall be described in the Member's Plan Document. In the event that a uniform plan of benefits is adopted, that Plan Document shall be prepared by PHI provided to each Member. The Plan Document may be amended from time to time to provide alternative or additional types of coverage. Insurance carriers shall be selected by PHI, which shall review all policies of insurance coverage. Member shall notify PVO or its designated representative of the identity of all Covered Persons and supply any other relevant personnel data as may be deemed necessary for the administration of the Program.

4.02 Confidentiality of Medical Information. PHI shall adopt policies and procedures to ensure and maintain the confidentiality of any individually identifiable medical information of Covered Persons, including but not limited to protected health information under HIPAA, the names of individuals who have filed claims for health care benefits, the amount of claims filed or paid on behalf of any Covered Person, and the medical records relating to any claims, all of which shall not be public records. Reports required to be made by PHI under this Agreement to Member shall identify claims paid by the line of coverage but shall not include any identification of the individual who filed a claim or to whom benefits were paid; provided however, it is expressly understood that no Member with fewer than 100 Covered Parsons shall have access to the Member's claims history.

(i) All contributions for the period prior to the termination during which participation in PHI was extended to the Member;

(ii) The Member's share of Program Costs through the effective date of termination;

(iii) Any additional administrative costs, including audit or accounting fees incurred by PHI to calculate the Member's termination obligations, including the Reserve Deficit as provided herein, unless otherwise waived by the Board;

(iv) The Member's Reserve Deficit, which shall consist of (i) the Member's proportionate share of any debt incurred by PHI during the Member's term of membership, and (ii) the Member's proportionate share of incurred but not reported claims through the date of termination; and

(v) Any attorneys' fees, costs, or expenses incurred in seeking to recover (a) the contributions; (b) the Member's share of Program Costs; (c) any additional administrative costs; (d) the Member's Reserve Deficit; and/or (e) the attorneys' fees, costs, and expenses incurred. Any amounts due under this Section shall immediately be due and payable.

6.03 Reserve Deficit. The Reserve Deficit for each Member shall be calculated through the effective date of the Member's termination from PHI. In determining a Member's proportionate share of any of the assessments set forth in this Article IX, the number of Member's Covered Persons will be divided by the total number of Covered Persons in the Program. The resulting quotient shall be the factor used in determining a Member's proportionate share of any termination assessments.

6.04 Termination by PHI. Upon a vote of the Board and with no less than five days' advanced written notice, a Member's participation may be terminated, if such a Member materially breaches or violates the terms of this Agreement or makes any misrepresentations to PHI or any third-party providing services to PHI. Without limiting the generality of the foregoing, the failure of a Member to promptly make payments PHI in complete conformity with the provisions of this Agreement shall be deemed to be a material breach and violation of this Agreement, warranting termination. In the event of termination by PHI, the terminated Member shall have no rights to share in any Surplus Funds then and/or thereafter found to be in existence. In addition, such Member shall, effective the day after the date on which such termination is effective, be wholly and solely responsible for providing the health care benefits that had previously been administered by PHI, including but not limited to any and all incurred but not reported liabilities and/or terminal liabilities related to its prior participation in PHI, and PHI shall have no liabilities related to the terminated Member's prior participation in PHI, and PHI shall have no liabilities to the Member in that or any regard.

6.05 Automatic Termination. This Agreement shall automatically terminate in the event of dissolution of PHI.

reason of any statute or rule of law, or shall be deemed null and void, the remaining provisions (or parts thereof) of this Agreement or the application of the particular provision or provisions (or parts thereof) to other facts or circumstances shall not be affected thereby and shall remain in full force and effect. It is the intention of the provisions of this Section to make clear that the agreement of the parties to this Agreement is that this Agreement shall be enforced insofar as it may be enforced consistent with applicable statutes and rules of law.

7.05 Notices. Except as otherwise specifically set forth in this Agreement, all notices, demands, requests, consents or approvals given, required or permitted to be given hereunder, shall be contained in writing and shall be deemed sufficiently given if actually received or if hand delivered, sent by facsimile or sent by recognized overnight delivery service-or by certified mail, postage prepaid and return receipt requested, addressed to the parties at the addresses set forth on the signature page or to such other address as the recipient shall have previously notified the sender of in writing, and shall be deemed received upon actual receipt (unless sent by certified mail, in which event such notice shall be deemed to have been received three (3) business days after the date of mailing).

7.06 Applicable Law. This Agreement and the rights of the parties hereto shall be interpreted in accordance with the laws of the State of Ohio.

7.07 Provisions Binding. This Agreement shall inure to the benefit of, and be binding upon, the parties and their respective heirs, executors, administrators, successors and assigns (except as may otherwise be specifically provided herein).

7.08 Captions. The table of contents and captions set forth herein are for convenience and reference only and are not intended to modify, limit, describe or affect in any way the contents, scope or intent of this Agreement.

7.09 Definitions. All terms used herein which are defined in this Agreement shall have the meaning set forth in this Agreement, unless the context clearly indicates otherwise.

7.10 Counterparts. This Agreement and any amendments hereto may be executed in two or more counterparts, each of which shall be deemed an original, but all of which shall constitute one and the same instrument. This Agreement may be executed electronically by the exchange of signature pages via email, facsimile or any other means. PHI shall maintain fully executed copy of this Agreement as executed by all the parties and to which shall be attached copies of all Exhibits and Schedules hereto as then in effect, and all signature pages, which counterpart shall be available for inspection by any Member upon reasonable request.

7.11 Word Meanings. The words such as "herein," "hereinafter," "hereof" and "hereunder" refer to this Agreement as a whole and not merely to a subdivision in which such words appear, unless the context otherwise requires. All pronouns and all variations thereof shall be deemed to refer to the masculine, feminine, or neuter, singular or plural, as the context in which they are used may require. Any reference to the Code, the Treasury Regulations, the Act, or other

IN WITNESS WHEREOF, the undersigned authorized person of the below noted political subdivision, pursuant to the attached resolution duly adopted by the political subdivisions governing body, executes this Agreement on behalf of said political subdivision, to signal the political subdivision's acceptance of this Agreement and enrollment in PHI as a Member.

"MEMBER":

Member Name:	
County:	
Signature:	
Printed Name:	
Date:	
Notice Address:	
Notice Email:	

IN WITNESS WHEREOF, the undersigned has duly executed this Agreement on behalf of PHI as of the date set forth below.

PUBLIC HEALTHCARE INITIATIVE BENEFITS PROGRAM "PHI":

Signature:	
Printed Name:	
Date:	

WAYPOINT BENEFIT SOLUTIONS

Russell Township in Geauga County

Benefit Comparison

	OPEC-HC Current		MEDICAL MUTUAL Proposed		UNITEDHEALTHCARE Proposed	
Benefits	***Network***	***Non-Network***	***Network***	***Non-Network***	***Network***	***Non-Network***
Annual Maximum	Unlimited		Unlimited		Unlimited	
Deductible	$2,500 / 5,000	N / A	$2,500 / 5,000	$3,000 / 6,000	$2,700 / 5,400	$7,500 / 15,000
Co-Insurance	100%	N / A	100%	60/40%	100%	60/40%
Out-of-Pocket	$2,500 / 5,000	N / A	$2,500 / 5,000	$7,500 / 15,000	$4,500 / 9,000	$15,000 / 30,000
Office Visits	Ded. Then 100%	N / A	Ded. Then 100%	Ded. & Co-Ins.	Ded. Then $25 Co-Pay	Ded. & Co-Ins.
Specialty Visits	Ded. Then 100%	N / A	Ded. Then 100%	Ded. & Co-Ins.	Ded. Then $50 Co-Pay	Ded. & Co-Ins.
Preventive	100%	N / A	100%	Ded. & Co-Ins.	100%	Ded. & Co-Ins.
Inpatient Facility	Ded. Then 100%	N / A	Ded. Then 100%	Ded. & Co-Ins.	Ded. Then 100%	Ded. & Co-Ins.
Outpatient Facility	Ded. Then 100%	N / A	Ded. Then 100%	Ded. & Co-Ins.	Ded. Then 100%	Ded. & Co-Ins.
Outpatient Services	Ded. Then 100%	N / A	Ded. Then 100%	Ded. & Co-Ins.	Ded. Then 100%	Ded. & Co-Ins.
Emergency	Ded. Then 100%		Ded. Then 100%		Ded. Then $250 Co-Pay	
Urgent Care	Ded. Then 100%	N / A	Ded. Then 100%	Ded. & Co-Ins.	Ded. Then $75 Co-Pay	Ded. & Co-Ins.
Prescription Drugs	Ded. Then 100%		Ded. Then 100%		Ded. Then $10/35/60 Card $25/87.50/150 Mail Order	
Monthly Premium	**$29,765.05**		**$38,808.64**		**$36,009.38**	

WAYPOINT BENEFIT SOLUTIONS

Coverage Type	Count	OPEC-HC Current	MMO Proposed	UHC Proposed
Employee Only	5	$544.55	$638.30	$586.30
Employee & Spouse	6	$1,086.54	$1,404.26	$1,169.83
Employee & Child(ren)	2	$893.34	$1,148.94	$1,224.67
Family	13	$1,441.26	$1,914.90	$1,816.12
Monthly Premium		**$29,765.05**	**$38,808.64**	**$36,009.38**

MEDICAL MUTUAL
FIND A PROVIDER

Follow link:
https://providersearch.medmutual.com/
Click on: Just looking around/GO
Select: Group
Select: SuperMed PPO Network

Enter Provider information and Provider type you desire along with Location. A list of providers in your area should appear.

UnitedHealthcare
FIND A PROVIDER

Follow link: https://www.uhc.com/
Click on: Find a Doctor
Select: Find a Physician, Hospital or Health Care Facility under "General Directory"
Select: The type of provider you are looking for.
Select: All Unitedhealthcare Plans
Select: Choice Plus

Enter Provider information and Provider type you desire along with Location. A list of providers in your area should appear.

WAYPOINT BENEFIT SOLUTIONS

The Dental Care PLUS GROUP

DELTA DENTAL

Russell Township	Current Delta Dental OPEC GUP	Proposed Dental Care Plus	Proposed Delta Dental PHI Plan	Proposed Delta Dental PHI High Plan
Maximum Payment	*$1,000 per person per calendar year*	*$1,000 per person per calendar year*	*$1,000 per person per calendar year*	*$2,000 per person per calendar year*
Deductible	*$50 / 150*	*$50 / 150*	*$50 / 150*	*$25 / 75*
Diagnostic & Preventive				
Exams, cleanings, fluoride	100%	100%	100%	100%
Emergency Palliative	100%	100%	100%	100%
Sealants	100%	100%	100%	100%
Brush Biopsy	100%	100%	100%	100%
Radiographs	100%	100%	100%	100%
Basic Services				
Minor Restorative	80%	80%	80%	80%
Endodontic Services	80%	80%	80%	80%
Periondontic Services	80%	80%	80%	80%
Oral Surgery	80%	80%	80%	80%
Major Services				
Major Restorative	50%	50%	50%	80%
Prosthodontic Services	50%	50%	50%	80%
Orthodontic Services				
Orthodontic Services	N / A	N / A	N / A	80%
Orthodontic Age Limit				*Up to age 19*

Coverage Type	Count	Rates	Rates	Rates	Rates
Employee Only	4	$25.70	$24.46	$25.50	$35.53
Employee + 1 or more	22	$68.88	$65.14	$73.25	$102.29
Monthly Total		**$1,618.16**	**$1,530.92**	**$1,713.50**	**$2,392.50**

WAYPOINT BENEFIT SOLUTIONS

Russell Township		Current OPEC VSP	VSP Proposed	Companion Life/Eye Med Proposed	Avesis Proposed
Exam Co-pay		*$10*	*$10*	*$10*	*$10*
Prescription Co-Pay		*$25*	*$25*	*$10*	*$25*
Prescription Glasses					
Frames & Lenses		$130 Allowance	$130 Allowance	$130 Allowance	$100 Allowance
Frequency		12 Months	12 Months	12 Months	12 Months
Contacts					
Contacts (instead of glasses)		$130 Allowance	$130 Allowance	$120 Allowance	$130 Allowance
Frequency		12 Months	12 Months	12 Months	12 Months
Coverage Type	**Count**	**Rates**	**Rates**	**Rates**	**Rates**
Employee Only	4	$5.99	$9.74	$8.23	$5.75
Employee +1	7	$11.77	$14.86	$15.51	$10.07
Employee + 2 or more	15	$18.94	$26.65	$24.40	$14.96
Monthly Total		**$390.45**	**$542.73**	**$507.49**	**$317.89**