

**CITY OF STRUTHERS**  
**Ordinance**

**NO. 25-007**

***AN ORDINANCE ESTABLISHING EMPLOYEE BENEFITS FOR 2025 AND  
AUTHORIZING THE AUDITOR TO TRANSFER THE EMPLOYEE AND  
EMPLOYER PREMIUM PAYMENTS TO THE HEALTHCARE  
ADMINISTRATION INTERNAL SERVICE FUND, AND TRANSFER  
BUDGETED FUNDS TO PAY ANY CLAIMS ABOVE CUMULATIVE FUNDS  
RETROACTIVE TO JANUARY 1, 2025, AND DECLARING AN  
EMERGENCY.***

**WHEREAS**, It is necessary to establish employee benefits for 2025. Exhibit A titled “Employee Benefit Elections” details employee benefits and sets premiums. It is necessary to fund the Healthcare administration ISF to administer the City of Struthers’s Self-insured healthcare plan. The Auditor needs to transfer the employee and employer premiums and any deficit claim requested for funding.

**NOW, THEREFORE, BE IT ORDAINED**, by the Council of the City of Struthers, Mahoning County, Ohio,  $\frac{3}{4}$ ’s of all members elected thereto concurring:

**SECTION 1:** Employee benefits are set for 2025 and are detailed in “Exhibit A” and attached hereto and made a part hereof: and

**SECTION 2:** It is understood that the Auditor can transfer employee premiums withheld from the payroll after each pay and the Auditor can transfer the employer share of premiums monthly from the 2025 budget category. In the event accumulated funds in the Healthcare Administration ISF are not sufficient to cover current claims the Auditor is authorized to transfer funds from the appropriate category from the 2025 budget to meet the obligation. The Auditor is also authorized to transfer any unused remaining employee share of healthcare premiums from all previous years from the Payroll account to the Healthcare Administration ISF Fund.

**SECTION 3:** Reference Ohio Revised Code section 9.833 Self-insurance programs for health care benefits, Ohio Revised Code section 5705.12 Establishment of funds.



**SECTION 4:** The provisions of this Ordinance are severable. If any section, paragraph, sentence, or clause hereof shall be declared illegal, unconstitutional or invalid by any court of competent jurisdiction, such illegality, unconstitutionality or invalidity shall not affect the remaining portions of this ordinance and it hereby is declared the intention and purpose of this Council that this Ordinance would have been enacted without such illegal, unconstitutional or invalid provision.

**SECTION 5:** It is hereby found and determined that all formal actions of this Council concerning and relating to the adoption of this Ordinance were passed in an open meeting of this Council and that all deliberations of this Council and of any of its committees that resulted in such formal action were in meetings open to the public, in compliance with all legal requirements including § 121.22 of the Ohio Revised Code.

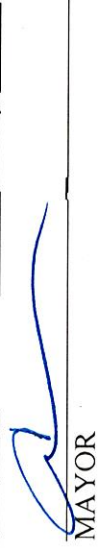
**SECTION 6:** This ordinance is hereby declared an emergency measure necessary for preserving public peace and the health and safety of the inhabitants of the City of Struthers, Ohio. Said emergency exists and, as such, this ordinance shall take effect upon its passage and approval by the Mayor.

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NO. 25-007

PASSED IN COUNCIL THIS 29<sup>th</sup> DAY OF January, 2025.  
  
CLERK OF COUNCIL  
  
PRESIDENT OF COUNCIL

FILED WITH THE MAYOR THIS 29<sup>th</sup> DAY OF January, 2025.  
  
CLERK OF COUNCIL

APPROVED BY THE MAYOR THIS 29<sup>th</sup> DAY OF January, 2025.  
  
MAYOR

POSTED ON STRUTHERS CITY WEBSITE & STRUTHERS SOCIAL MEDIA

DATE: January 31, 2025  
  
CLERK OF COUNCIL

Ordinance No. 25-007  
"Exhibit A"



24 deductions out of 26 pays

**Employee Benefit Elections**  
Effective: January 1, 2025 through December 31, 2025

The below illustrations include the In Network Benefits Only

 Utilizing the  PPO Network of Providers	<b>Base Plan</b> Embedded Deductible	<b>Buy Up Plan</b> Embedded Deductible
Calendar Year Deductible (CYD) Coinsurance (After CYD) Annual Out of Pocket Maximum (Includes CYD) Office Visit Copay (PCP/Specialist) Preventive Services Diagnostic Lab & X-Ray at Office Visit Diagnostic Lab & X-Ray at Facility Advanced Imaging (MRI, PET & CAT scans) Urgent Care Emergency Room, Doctor, Services Outpatient Services Inpatient Hospital	\$1,500 Individual / \$4,500 Family 30% After CYD \$4,400 Individual / \$8,800 Family \$10 / \$50 No Charge No Charge 30% After CYD 30% After CYD \$75 \$350 + 30% 30% After CYD 30% After CYD	\$1,500 Individual / \$3,000 Family 20% After CYD \$3,800 Individual / \$7,600 Family \$10 / \$50 No Charge No Charge 20% After CYD 20% After CYD \$75 \$350 + 20% 20% After CYD 20% After CYD
<b>Smit+Rx</b> 30 Day Retail Rx Tier: 1 / 2 / 3 / 4 90 Day or Mail Order Rx: 1 / 2 / 3 Specialty Drugs limited to a 30 day supply	\$10 / \$40 / \$70 / 25% up to \$350 \$25 / \$120 / \$210 / 25% up to \$350	\$10 / \$40 / \$70 / 25% up to \$350 \$25 / \$120 / \$210 / 25% up to \$350
Coverage Tier: Employee Only Employee + Spouse Employee + Child(ren) Family	Monthly Premium Per Pay Deduction	Monthly Premium Per Pay Deduction
	\$637.56 \$1,401.36 \$1,076.21 \$1,968.15	\$666.79 \$1,465.60 \$1,125.55 \$2,058.38
	<b>Dental Plan</b>	Per Pay Deduction \$66.68 \$146.56 \$112.56 \$205.84
	<b>Anthem Blue View Vision Plan</b> FS.B.20.20.130.130	Per Pay Deduction \$5.60 \$5.60 \$5.60 \$5.60
Exam Lenses Frames Contact Lenses	Tier EE ES EC Family	Monthly Premium Per Pay Deduction \$56.00 \$56.00 \$56.00 \$56.00
	\$20 \$20 Up to \$130 Allowance - then 20% off any remaining balance Elective: Up to \$130 Allowance Non-Elective: Covered in Full	Tier EE ES EC Family
	every 12 months every 12 months every 24 months every 12 months	Monthly \$4.82 \$9.65 \$10.92 \$17.16
	\$0.48 \$0.97 \$1.09 \$1.72	
*Please refer to your full evidence of coverage and/or benefit summary for complete and accurate information.		
<b>Please indicate your coverage election for all benefits, sign and date below.</b>		
<b>BASE Plan + Dental + Vision</b>	<b>BUY UP Plan + Dental + Vision</b>	
Monthly Premium Per Pay Deduction \$698.38 \$1,467.01 \$1,143.13 \$2,041.31	Monthly Premium Per Pay Deduction \$727.61 \$1,531.25 \$1,192.47 \$2,131.54	Monthly Premium Per Pay Deduction \$72.76 \$153.13 \$119.25 \$213.15
Employee Name: _____	Employee Name: _____	Employee Name: _____
Date: _____	Date: _____	Date: _____
<b>Employee Signature: _____</b>		
<b>Employee Signature: _____</b>		
<b>Employee Signature: _____</b>		

**Waiver of Coverage: Check the box and sign below**

I would like to WAIVE Medical Coverage in BOTH plans for myself and any eligible dependents:  
 I would like to WAIVE Dental Coverage for myself and any eligible dependents:  
 I would like to WAIVE Vision Coverage for myself and any eligible dependents: