Attachment to Ordinance #2499-2021
Amending Police Management Compensation Plan (MCP) #2715-2013, as amended

Section 1. To amend Ordinance No. 2715-2013, as amended, by enacting Section 6(F) to read as follows:

(F) COVID-19 Vaccine Incentive.

The City shall provide every full-time and non-temporary/non-seasonal part-time employee of the Police Management Compensation Plan $500.00, less applicable withholdings, for being fully vaccinated against COVID-19 on or before December 1, 2021.

To receive the vaccine incentive, employees must demonstrate the receipt of the vaccine by providing a copy of the original CDC COVID-19 Vaccination Record Card demonstrating receipt of one (1) dose of the Johnson & Johnson/Janssen vaccine or two (2) doses of the Pfizer-BioNTech or Moderna vaccines; and

(1) The COVID-19 Vaccination Record Card will be kept in the employee's medical file (separate from the personnel file); and

(2) The provision of the copy of the COVID-19 Vaccination Record Card by the employee to Human Resources is considered the employee's affirmation that the copy is a true representation of the original and that the employee did receive the vaccination.

Section 2. To amend Ordinance No. 2715-2013, as amended, by amending Section 8 to read as follows, while repealing the current section:

SECTION 8. INSURANCE.

(A) Health Insurance. The City shall continue to provide comprehensive major medical, dental, vision care, life insurance and prescription drug benefits for all full-time employees as are now in effect, with modifications as detailed below, for both the employee and family coverage. Employees shall become eligible for such benefits on the first of the month following their hire date. If hired on the first day of the first month, the employee's coverage will begin immediately. This coverage shall also comply with all pertinent state and federal statutes, including the Health Insurance Portability and Accountability Act (HIPAA) and the Newborns' and Mothers' Health Protection Act (NMHPA) of 1996.

(B) Comprehensive Major Medical.

(1) If the employee and/or dependent receives services from a preferred provider (PPO), reimbursements will be at an eighty/twenty percent (80/20%) co-insurance and will be subject to single and family deductible and out-of-pocket maximums listed in Table 1.

Deductibles, Out-of-Pocket Maximums and visit limits will fully reset on January 1st of each year.

(2) If a preferred provider is not used, coinsurance will be reduced to sixty/forty percent (60/40%) of one hundred forty percent (140%) of the published reimbursement rates allowed by Medicare and subject to the single and family deductibles and out-of-pocket maximums listed in Appendix F. Any network modifications made by the plan administrator will apply.

Deductibles, Out-of-Pocket Maximums and visit limits will fully reset on January 1st of each year.

(3) Physician office visits will be subject to co-payments per in-network primary care physician visits listed in Table 1. Eligible services, which shall include diagnostic, surgical and/or specialty services provided in the network physician's office and billed by that office shall be covered at one hundred percent (100%) after office visit co-payment.

(4) The office co-payment does not apply to the annual deductible, however, office co-payments will apply to the annual out-of-pocket maximum. Care rendered by non-network providers shall be subject to the annual

deductible, co-insurance, and out-of-pocket maximum as specified in Section 16(B)(1) and 16(B)(2), and a twenty percent (20%) penalty.

(5) Pursuant to the NMHPA, all inpatient and outpatient treatment for psychiatric and/or alcohol or drug treatment (substance abuse) services will not be subject to treatment limits and will be covered as standard medical treatment. Coverage is subject to deductible, co-insurance, and out-of-pocket maximums.

(6) In-Patient Hospital Coverage. After satisfying the annual deductible, the plan pays eighty percent (80%) of reasonable charges for a semi-private room and ancillary services for medical stays at an in-network hospital. Once out-of-pocket expenses and reasonable charge provisions have been met, the plan will reimburse the hospital at one hundred percent (100%) for covered services.

For utilization at a non-network hospital, an additional twenty percent (20%) penalty and any excess charges above reasonable rates are the employee's responsibility. Any charges for medically unnecessary care, non-covered services or charges beyond plan limitations are the employee's responsibility.

The Healthcare Plan will require "medical necessity" for all services.

(7) In accordance with the Patient Protection and Affordable Care Act of 2010, insured members are eligible to receive certain preventive care services, based upon age, gender and other factors, without cost-sharing (co-payments, co-insurance and deductibles). These preventive services must be provided by doctors and health care professionals within the City's plan provider network. The preventive health services that must be covered without cost-sharing requirements are those based on the requirements stated below:

(a) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF), including certain preventive care for women, such as mammograms, cervical cancer screenings and prenatal care;

(b) Immunizations for routine use in children, adolescents and adults that are currently recommended by the Centers for Disease Control and Prevention (CDC) and included on the CDC's immunization schedules;

(c) Strong scientific evidence-informed preventive care and screenings for infants, children and adolescents, as provided for in the Health Resources and Services Administration (HRSA) guidelines; and

(d) As noted above, a set of additional scientific evidence-based preventive services for women recommended by the Institute of Medicine and supported by HRSA.

Preventive services that are excluded from the above agencies' recommended lists shall be subject to the annual deductible, co-insurance, and out-of-pocket maximum as specified in Sections 16(B)(1) and 16(B)(2).

Preventive services rendered by non-network providers shall be subject to the annual deductible, co-insurance, and out-of-pocket maximum as specified in Table 1.

Insured members should contact the City's health plan administrator prior to obtaining preventive services for determination of preventive services coverage.

In addition to the preventive services provided for under the ACA, the City shall maintain preventive coverage and limits for the following services:

a) Provide coverage for an annual (one (1) per calendar year) routine prostate/colon rectal cancer tests for men age 40 and over.

b) For men age 40 and over, an annual (one per calendar year) PSA blood test will be covered.

c) Provide coverage for one (1) baseline mammogram for women 35-39 years old.

(8) An emergency room visit will be subject to a seventy-five-dollar ($75.00) co-payment per visit. If admitted, the co-payment will be waived. An urgent care visit will be subject to a thirty-dollar ($30.00) co-payment per visit.

(9) Miscellaneous benefits with specified limits:

Physical therapy, occupational therapy, and/or chiropractic visits will be covered up to a combined annual maximum for thirty (30) visits per person, based on medical necessity.

Prescription drug deductible charges are not payable under this medical provision.

The City will provide the following minimum coverage for maternity benefits: At least forty-eight (48) hours of inpatient hospital care following a normal vaginal delivery; and at least ninety-six (96) hours of inpatient hospital care following a caesarean section and physician-directed aftercare. These minimum stay requirements are not applicable if the mother and her health care provider mutually agree that the mother and her child may be discharged earlier.

A weight loss schedule is limited to examination charges only. Food supplements in the treatment of obesity are excluded.

Temporomandibular joint pain dysfunction, syndrome or disease or any related conditions collectively referred to as "TMJ" or "TMD" will be covered on the basis of medical necessity. This does not apply to surgical services on the jaw hinge.

(C) Prescription Drugs. The City will provide a prescription drug coverage plan that provides for the use of a formulary, step therapy, quantity level limits, exclusions and prior authorization.

(1) CO-PAYMENTS AND OUT-OF-POCKET MAXIMUMS
The employee shall be responsible for a five-dollar ($5.00) co-payment for a Tier 1 drug. For a Tier 2 drug, the co-payment is fifteen dollars ($15.00). For a Tier 3 drug, or if a prescription is written “dispense as written” and a lower tier drug exists, the co-payment is thirty dollars ($30.00). The annual out-of-pocket maximum per single contract per year will be two thousand dollars ($2000.00). The annual out-of-pocket maximum per family contract per year will be four thousand dollars ($4000.00).

(2) MAIL ORDER

Mail order prescription drugs will be limited to a thirty (30) day minimum and a ninety (90) day maximum supply. The out-of-pocket maximum for prescription drugs filled through mail order will be the same as described in Section 16(C)(1). Under the mail order program, the employee shall be responsible for a twelve dollars and fifty cents ($12.50) co-payment for a Tier 1 drug. For a Tier 2 drug, the co-payment is twenty-five dollars ($25.00). For a Tier 3 drug, or the prescription is written “dispense as written” and a generic equivalent exists, the co-payment is sixty dollars ($60.00).

Maintenance drugs may be obtained through the mail order program. The original prescription with no refills may be purchased locally and subsequent refills may use the mail order program.

The prescription drug program will include prior authorization requirements for certain types of drugs. Some drugs will require the employee and/or dependent to undergo step therapy (trial of a lower cost drug before a higher cost drug is covered). The prescription drug program administrator will determine which drugs require prior authorization and/or step therapy.

(3) The City's prescription drug coverage plan will include the following clinical programs:

(a) Formulary.
Tier changes to the formulary will happen once per year, customarily in January.

(b) Exclusions.
Under the exclusion program prescription drugs may be excluded from the formulary only if an equivalent generic or therapeutically equivalent prescription drug remains available on the formulary or over-the-counter.

(c) Prior Authorization.
Prior authorization (PA) requires your doctor to explain why you are taking a medication to determine if it will be covered under the pharmacy benefit.

(d) Step Therapy.
Trial of a lower cost drug before a higher cost drug is covered.

(e) Specialty Pharmacy.

The City's Pharmacy Benefits Manager (PBM) will determine which drugs are included in any or all of these clinical programs and the applicable quantity level limits subject to the restrictions noted above.

(4) SERVICES NOT COVERED

- Experimental drugs.
- Drugs that may be dispensed without prescription.
- Non-prescription items.

- Medications which are covered under the terms of any other employer, sponsored group plan, or for which the individual is entitled to receive reimbursement under Workers' Compensation or any other Federal, State or Local governmental program.
- Immunization Agents (except as provided in Section 16(B)(7)(b)).
- Drugs deemed not medically necessary.
- Administration of prescription drugs.
- Any prescription refill in excess of the number specified by the physician, or any refill dispensed after one year from date of the physician's original order.
- Medication taken by, or administered to, the individual while a patient is in a licensed hospital, extended care facility, nursing home or similar institution which operates, or allows to be operated, on its premises, a facility for dispensing drugs.
- Anti-obesity drugs.
- Dietary and food supplements.

(5) DISPENSING LIMITATION

Each retail prescription may be filled up to a maximum of a thirty (30) day supply and a maximum of a ninety (90) day supply for mail order.

(6) MISUSE OF PRESCRIPTION DRUG PROGRAM

Control Drug Management Program. The City's prescription drug program administrator will review prescriptions to assess whether abuse of narcotics and similar drugs may be occurring and will follow up with prescribing physicians as appropriate to further evaluate any suspected instances of abuse.

Misuse or abuse of the prescription drug program, verified by the appropriate law enforcement agency, shall result in suspension of the employee's prescription drug card for a period of twelve (12) months. As used herein, verification of misuse or abuse of the prescription drug program occurs when the appropriate law enforcement agency files criminal charges against the employee or dependent, or refers (diverts) the employee or dependent to a counseling and rehabilitation program in lieu of criminal charges. If the employee/dependent is found not guilty, the prescription drug card shall be reinstated.

(D) High Deductible Health Plan/Health Savings Account Design Option.
Effective for the plan year beginning January 1, 2023, the City shall offer a non-mandatory HDHP to all benefit eligible employees. The plan will be based on the medical plan coverage design, except as follows:

Benefit	Single	Family

Deductible		
In-Network	$1500	$3000
Non-Network	$3000	$6000
Out of Pocket Maximum		
In-Network	$3000	$6000
Non-Network	$6000	$9000

If more than one person in a family is covered under the policy, the single deductible and out-of-pocket limit does not apply. The HDHP has a combined Medical and Pharmacy Deductible and Out of Pocket Maximum and the Out-of-Pocket Maximum includes Deductible and Coinsurance for both Medical and Pharmacy Claims. After the deductible is met, both Medical and Pharmacy claims are paid at the coinsurance level until the Out of Pocket Maximum is met.

During each plan year, the annual deductibles and out-of-pocket maximums will be increased if and to the extent necessary to maintain the option's status as a high deductible health plan under the Internal Revenue Code.

For each employee that elects HDHP coverage the City shall contribute into an employee established health savings account at a financial institution chosen by the City and contribute five hundred dollars ($500.00) for single coverage and one thousand dollars ($1,000.00) for family coverage in 2023.

In 2024, the City contributions will be made on a semi-annual basis in January and July in the amount of three hundred dollars ($300.00) for single coverage and six hundred dollars ($600.00) for family coverage.

For those employees who do not elect coverage under the HDHP, there will be no health savings account contribution from the City.

(E) Dental.

(1) DENTAL ANESTHESIA

Dental general anesthesia administered by the dentist is a Covered Service. Osseous surgery is not covered under the dental plan, but is payable under the medical plan.

(2) ANNUAL DENTAL MAXIMUM

The maximum amount payable for covered dental expenses, except orthodontics, for one (1) eligible person in one (1) benefit year is fifteen hundred dollars ($1,500.00).

(3) ORTHODONTIC MAXIMUM

The lifetime maximum payable for dependent orthodontia services for any covered child is eighteen hundred-fifty dollars ($1,850.00).

(4) A dental PPO shall be available to employees which allow voluntary selection of a participating network provider which will result in no-balance billing over reasonable charges. All existing coinsurance levels and exclusions continue to apply.

(5) The following preventative dental services are paid at 100% of the reasonable charge:

(a) Routine oral examinations – twice in any calendar year, January 1 through December 31.

(b) Routine prophylaxis (cleaning of teeth) – twice in any calendar year, January 1 through December 31.

(c) Topical application of fluoride –in any calendar year, January 1 through December 31.

(F) Vision. The City shall maintain the current vision care plan for all eligible employees as follows:

(1) In-Network Plan

Deductibles:
Eye Examination $5.00
Lenses and Frames $12.50
Deductibles do not apply toward contact lenses.

Wholesale Frame Allowance	Retail Frame Allowance
$41	$135

(2) Out-of-Network Plan Reimbursement Schedule

Eye Examination up to	$35.00
Frames up to Lenses	$35.00
Single Vision up to	$35.00
Bifocals up to	$35.00
Trifocals up to	$60.00
Lenticular up to	$90.00

(3) Contact Lenses (pair) in place of all other plan benefits for the benefit period

Cosmetic (elective)	$90.00 plus exam
Necessary	$170.00 plus exam

(G) Life Insurance. The City shall maintain term life insurance in the amount of one and a half times the employee's annual salary in effect at the time of death for all full-time employees less than sixty-five (65) years of age, not to exceed two hundred thousand dollars ($200,000). Full-time employees, sixty-five (65) to seventy (70) years of age shall receive term life insurance in the amount of sixty-five percent (65%) of one and a half times the employee's annual salary in effect at the time of death not to exceed sixty-five thousand dollars ($65,000). Full-time employees seventy (70) years of age and over shall receive term life insurance in the amount of thirty-nine percent (39%) of one and a half times the employee's annual salary in effect at the time of death not to exceed thirty-nine thousand dollars ($39,000). Employees who have health insurance from other sources may elect to purchase life insurance coverage only, and shall pay a monthly premium of five dollars and fifty cents ($5.50) for such life insurance coverage. Employees are eligible to purchase additional life insurance through a program established by the Department of Human Resources. Upon termination, employees would be eligible to continue life insurance coverage at the market rate at their own expense.

(H) Eligibility. Eligibility for enrolling new employees for health insurance, dental insurance, vision care, prescription drug and life insurance shall be based upon an employee's active service in a position or employment, which is to be performed in accordance with an established scheduled working time, such schedule to be based upon not less than forty (40) hours per seven (7) consecutive calendar days for fifty-two (52) consecutive seven (7) day periods per annum unless otherwise required by Federal Law or Regulations. Employees shall become eligible for the benefits outlined in this Section 16, pursuant to the provisions herein, on the first of the month following their hire date, unless hired on the first of the month coverage is effective immediately.

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(1) Full-time employees may waive coverage in the employee insurance programs during the annual Open Enrollment period. Once the waiver is executed, the employee must wait until the next annual Open Enrollment period in a subsequent year to re-enroll in the benefit plans. In the event of

a divorce, legal separation, the death of a spouse or the spouse involuntarily loses family coverage through the spouse's employer, the employee may enroll with the City of Columbus insurance program within thirty (30) days of such event.

(2) Part-time regular employees who have worked a minimum of one thousand forty (1,040) hours the previous calendar year shall be eligible for medical, prescription drug, dental, and vision. The employee's share of the cost of the medical and prescription insurance will be thirty percent (30%) of the established funding rate established by the Department of Finance and Management. The employee's share will be converted into a single and family premium. An open enrollment will be held each year for employee enrollment. In the event of a divorce, legal separation, the death of a spouse, or the spouse involuntarily loses family coverage through the spouse's employer, the eligible employee may enroll with the City of Columbus insurance program within thirty (30) days of such event.

For purposes of this paragraph (F) (2), "hours" counted toward part-time eligibility will include hours worked, Paid Time Off, Personal Business Day, Injury Leave, Workers' Compensation, Military Leave, and FMLA.

(I) Premium Contribution. The monthly premium will be an amount equal to seventeen percent (17%) of the funding rate established by the actuary for the City for single and family coverage. For all employees hired on or after October 1, 2017, the monthly premium shall be an amount equal to twenty percent (20%) of the funding rate established by the actuary for the City for single and family coverage.

Such premiums shall be paid through an automatic payroll deduction. Half of the monthly premium will be deducted each pay period not to exceed the total monthly premium.

Providing an employee continues monthly premium coverage payments, insurance coverage for which an employee is eligible will be extended ninety (90) days beyond the end of the month during which an employee's approved leave without pay or leave of absence status became effective. The employee's insurance will then be terminated with an option to participate in the City's insurance continuation program, COBRA, at the employee's expense.

Employees on disability leave, or employees receiving payments in lieu of wages from the Ohio Bureau of Workers' Compensation, must keep their premium payments current. If at the conclusion of the ninety (90) day period as specified in the previous paragraph, the premium payments are not current, an employee's insurance will then be terminated with an option to participate in the City's insurance continuation program, COBRA, at the employee's expense.

(J) Tobacco Surcharge. If an employee hired on or after January 1, 2018 who participates in the City's insurance program uses tobacco, the employee will be charged a twenty-five dollar ($25.00) per month surcharge.

(K) Employees are eligible to pre-tax insurance premium contributions.

The City will continue to maintain an IRC Section 125 Plan whereby employees will be able to pay for their share of health insurance premiums with pre-tax earnings. This plan will remain in effect so long as it continues to be permitted by the Internal Revenue Code. Such premiums shall be paid through an automatic payroll deduction.

(L) The City may afford employees the opportunity to participate in a voluntary pre-paid legal services plan payable through payroll deduction.

(M) Cancer Advocacy.
The City shall engage a cancer treatment advocate effective plan year 2022. The cancer advocacy program supports employees and family members with the diagnosis of cancer.

(N) Appeal Process. The extent of coverage under the insurance policies (including self-insured plans) shall be governed by the terms and conditions set forth in said policies or plans. Any questions or disputes concerning an employee's claim for benefits under said insurance policies or plans shall be resolved in accordance with the terms and conditions set forth in said policies or plans, including the claims appeal process available through the insurance company or third party administrator. In the event the plan summaries, booklets, certificates and this Ordinance are not specific, the plan administrator's administrative guidelines will prevail; provided, however, that this shall not prejudice the right of the employee to appeal a claim dispute to the plan administrator and to the Ohio Department of Insurance.

(O) Table 1.

Table 1	
Deductible	
In-Network	$300 single / $600 family
Non-Network	$800 single / $1,600 family
Co-insurance	
In-Network	80% / 20%
Non-Network	60% / 40%
Out-of-Pocket Maximum	
In-Network	$700 single / $1,200 family
Non-Network	$1,600 single / $3,200 family
Office Visit Co-pay	
Primary Care	$20 co-pay
Specialist	$30 co-pay
Hospital Inpatient Stay	
In-Network	20% after deductible
Non-Network	40% after deductible
Outpatient Surgery	
In-Network	20% after deductible
Non-Network	40% after deductible
Emergency Room Co-pay	
In-Network	$75 co-pay, 20% after co-pay and deductible (co-pay waived if admitted)
Non-Network	same as in-network
Urgent Care Co-pay	
In-Network	$30 co-pay, 20% after co-pay and deductible
Non-Network	$30 co-pay, 40% after co-pay and deductible
Lifetime Maximum	No maximum
Pre-Notification Penalty	Benefits reduced to 50**%** of eligible expenses
Rx Co-pays	Retail/Mail
Tier 1	$5/$12.50
Tier 2	$15/$25
Tier 3/ Dispense as Written	$30/$60
Rx Co-pays Accumulate	Yes
Rx OOP Max	$2,000 single/ $4,000 family
Tobacco Surcharge	$25.00 monthly for new hires as of January 1, 2018

Section 3. To amend Ordinance No. 2715-2013, as amended, by amending Section 13 to read as follows:

SECTION 13. INJURY LEAVE WITH PAY.

(A) All employees shall immediately report each injury believed to be service-connected to their immediate or acting supervisor. The employee shall complete and submit the City of Columbus accident report to the Division's Human Resources representative within forty-eight (48) hours. If the employee is physically unable to comply with the forty-eight (48) hour deadline, the employee's immediate or acting supervisor will complete the accident report on the employee's behalf, and forward to the Division's Human Resources representative and the Division's Safety Officer. Failure to follow the reporting procedure may result in discipline.

The employee's obligation to report his/her injury under this section is not a condition precedent to being eligible for or receiving injury leave.

Whenever an employee is required to stop working because of an injury or other service connected disability, the employee shall be paid for the remaining hours of that day, or shift, at the employee's regular rate and such time shall not be charged to leave of any kind.

(B) Requirements for Receiving Injury Leave. All employees shall be allowed Injury leave with pay not to exceed one hundred eighty (180) days upon verification of the following:

(1) An order of the BWC, Industrial Commission or court allowing the workers' compensation claim for the conditions disabling the employee per MEDCO 14 or equivalent presented by the approved medical provider and the City has not appealed the claim allowance; and

(2) A BWC approved medical provider of the employee's choosing determines that the employee is temporary and totally disabled; and

(3) The employee submits a MEDCO 14 or equivalent issued by the employee's BWC approved medical provider of record to the Division's Human Resources representative. Injury leave will continue to be paid as long as it is supported by MEDCO 14 or equivalent from the employee's BWC approved medical provider.

(C) Return to Work. No employee on injury leave shall be returned to work without written approval of the employee's BWC approved medical provider.

(D) Continued Contact with Department and Return to Work Notification.
An employee on injury leave shall maintain biweekly contact with the Division's Human Resources representative or designee during the period of time the employee is injured. This requirement may be modified in writing by the Division's Human Resources Representative or designee for extended leaves. An employee shall notify the Division's Human Resources representative or designee at least seven (7) days before the expected return to work date to confirm that date.

(E) Employees receiving injury leave shall not:

(1) Engage in any outside activity inconsistent with restrictions or medical advice or that adversely affects the employee's recovery, as established by the employee's BWC approved medical provider; or

(2) Knowingly make a false or misleading statement, or alter, falsify, destroy or conceal any document in order to receive injury leave.

Violation of this section may result in discipline.

(F) Termination of Benefits. Injury leave will terminate:

(1) When the employee's BWC approved medical provider releases the employee back to work or for transitional duty; or

(2) For duty hours during which the employee is incarcerated; or

(3) When Temporary Total benefits under the employee's workers' compensation claim are denied by the BWC or Industrial Commission; or

(4) When the Industrial Commission or the employee's BWC approved medical provider determines the employee is no longer entitled to Temporary Total benefits because the employee has reached Maximum Medical Improvement, unless such benefits are reinstated following an appeal to court; or

(5) If the employee is disqualified from workers' compensation benefits; or

(6) If the employee accepts workers' compensation Temporary Total disability benefits; or

(7) When an employee is provided an opportunity to perform transitional duties within the restrictions provided by the employee's BWC approved medical provider and refuses.

No Injury leave time will be restored to an employee who has separated from City service.

(G) Injury leave found to be paid in error due to the employee's return to work, medical evidence of ability to return to work, employee's refusal to return to work in a transitional duty assignment approved by the employee's BWC approved medical provider, or the fraudulent receipt of injury leave while performing work outside employment shall be promptly repaid to the City.

The 180 days of injury leave will be paid through the end of the fifth calendar year following the original date of injury or diagnosis as determined by the BWC.

(H) Claims for certain occupational disease:

(1) Cardiac disabilities shall be presumed to be service-connected injuries.

(2) Respiratory and pulmonary disabilities shall be considered on a case by case basis for determination of whether or not they are service-connected injuries.

(I) Leave Pending Decision. Pending a decision on the allowance of the employee's workers' compensation claim, an injured employee may be carried on personal sick leave with pay which shall be restored to the employee's credit upon certification by the Director of Human Resources or designee, that injury leave has been approved; except that when an employee is injured, and the Fire Chief can establish that the injury occurred during the employee's hours of work for the City, the employee may be carried on injury leave with pay pending certification by the Director of Human Resources or designee, that the conditions of Section (B) have been satisfied. In no case may the employee be carried on injury leave in excess of the employee's amount of accumulated sick leave. If injury leave is not certified by the Director of Human Resources or designee, the employee will be charged sick leave for time used. Injury leave shall be allowed for actual time spent during duty hours (including travel time) for scheduled physician appointments and/or treatments resulting from an on-the-job injury.

(J) Additional Injury Leave. If an employee is unable to return to regular duty after exhausting his/her available injury leave due to a serious medical condition or complication relating to the injury, the employee may apply for up to one hundred eighty (180) calendar days of additional injury leave and

this application shall be considered on a case-by-case basis by the City. This additional injury leave shall be granted if supported by appropriate medical documentation of the serious medical condition or complication and the employee, during the period of initial injury leave, has followed prescribed medical treatment.

Section 4. That existing Sections 6, 8, and 13 of Ordinance No. 2715-2013, as amended, are hereby repealed.

Section 5. For reasons stated in the preamble hereto, which is hereby made a part hereof, this ordinance is hereby declared to be an emergency measure and shall take effect and be in force from and after its passage and approval by the Mayor or ten (10) days after passage if the Mayor neither approves nor vetoes the same.