

RESOLUTION NO. 83-2026

Introduced by Monty Tapp

A RESOLUTION RATIFYING THE CITY MANAGER'S ACCEPTANCE OF THE PROPOSAL AND EXECUTION OF AN AGREEMENT WITH ARLO/COVET HEALTH FOR THE PROVISION OF MEDICAL HEALTH INSURANCE COVERAGE FROM OCTOBER 1, 2026 THROUGH SEPTEMBER 30, 2027.

WHEREAS, the City of Huron used a third-party benefits administrators to obtain pricing for the 2026/2026 medical coverage for its full-time employees;

WHEREAS, the City of Huron held an Open Enrollment for 2026/2027 benefits for its full-time employees starting on September 14, 2026;

WHEREAS, it was necessary to execute the agreement with Covet Health prior to the first regular Council meeting in October in order to allow for Open Enrollment for 2026/2027 benefits to be effective as of October 1, 2026.

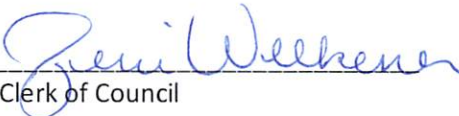
NOW, THEREFORE, BE IT RESOLVED BY THE COUNCIL OF THE CITY OF HURON, OHIO:

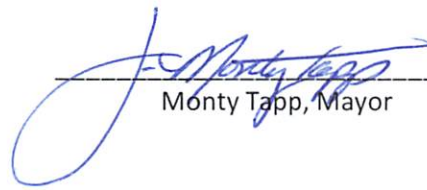
SECTION 1. That the City Manager's acceptance of the proposal and execution of a new agreement with Covet Health for the provision of 2026/2027 healthcare insurance coverage, a copy of which is attached hereto as Exhibit "A" and made a part hereof, is hereby ratified.

SECTION 2. That this Council hereby finds and determines that all formal actions relative to the adoption of this Resolution were taken in an open meeting of the Council and that all deliberations of this Council and of its committees, if any, which resulted in formal action, were taken in meetings open to the public in full compliance with applicable legal requirements, including O.R.C. § 121.22 of the Revised Code.

SECTION 3. That this Resolution shall go into effect and be in full force and effect immediately upon its adoption.

ATTEST:


Clerk of Council


Monty Tapp, Mayor

ADOPTED:

22 SEP 2026



2026 Covet Health Current Vs Renewal

GENERAL INFORMATION

Funding Type
Association (if applicable)
Plan Type
Network Indicator
Benefit Summary

BENEFIT SUMMARY

Annual Deductible/Individual
Annual Deductible/Family
Coinsurance
Office Visit/Exam
Outpatient Specialist Visit
Annual Out-of-Pocket Limit/Individual
Annual Out-of-Pocket Limit/Family
Deductible Included in Out-of-Pocket Limits
Deductible Embedded
Inpatient Hospital Services
Surgical Services
Emergency Services
Urgent Care
Prescription Drug Benefits
Prescription Drug Deductible
Retail
Generic / Tier 1
Brand (Formulary/Preferred) / Tier 2
Brand (Non-Formulary/Non-preferred) / Tier 3
Specialty / Tier 4
Mail Order
Generic / Tier 1
Brand (Formulary/Preferred) / Tier 2
Brand (Non-Formulary/Non-preferred) / Tier 3
Specialty / Tier 4

FINANCIAL SUMMARY

	Enroll #
EE	18
EE & Spouse	4
EE & Child(ren)	12
Family	16
Total Monthly Liability	
Total Annual Liability	
Premium Change (%)	
Rate Guarantee	

Current

Covet Health

Fully Insured
N/A
H.S.A.
Cigna
\$5000 H.S.A.

In-Network Out-of-Network

\$5,000	\$12,000
\$10,000	\$24,000
0%	50%
Ded/0%	Ded/50%
Ded/0%	Ded/50%
\$5,000	\$20,000
\$10,000	\$40,000
Yes	Yes
Yes	Yes
Ded/0%	Ded/50%
Ded/0%	Ded/50%
	Ded/0%
Ded/0%	Ded/50%
Combined with Medical	
Ded/0%	Not Covered
Ded/0%	Not Covered
Ded/0%	Not Covered
Ded/0%	Not Covered
Ded/0%	Not Covered
Ded/0%	Not Covered
Ded/0%	Not Covered

Renewal

Covet Health

Fully Insured
N/A
H.S.A.
Cigna
\$5000 H.S.A.

In-Network Out-of-Network

\$5,000	\$12,000
\$10,000	\$24,000
0%	50%
Ded/0%	Ded/50%
Ded/0%	Ded/50%
\$5,000	\$20,000
\$10,000	\$40,000
Yes	Yes
Yes	Yes
Ded/0%	Ded/50%
Ded/0%	Ded/50%
	Ded/0%
Ded/0%	Ded/50%
Combined with Medical	
Ded/0%	Not Covered
Ded/0%	Not Covered
Ded/0%	Not Covered
Ded/0%	Not Covered
Ded/0%	Not Covered
Ded/0%	Not Covered
Ded/0%	Not Covered

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Cigna \$5000 Platinum Employee Health Plan

Coverage Period: 10/1/2026 to 9/30/2027
Coverage for: Individual & Family | Plan Type: HSA



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact Covet Health at 1-909-315-4751. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-909-315-4751 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Provider: \$5,000 / Individual or \$10,000 / Family Out-of-Network \$12,000 / Individual or \$24,000 / Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. <u>Deductible</u> accumulations are per Calendar year.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your <u>deductible</u> .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your <u>deductible</u> . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Network Provider \$5,000 / Individual or \$10,000 / Family Out-of-Network \$20,000 / Individual or \$40,000 / Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limit</u> until the overall family <u>out-of-pocket limit</u> has been met. Accumulations are per Calendar year.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	This benefits package uses a <u>network of providers</u> up to a maximum benefit limit. For a list of <u>network providers</u> , see <u>Cigna</u> : Phone Number: 1-909-315-4751	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a specialist?	No.	You do not need a referral to see a specialist.

 All coinsurance costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	50% coinsurance	None.
	Specialist visit	0% coinsurance	50% coinsurance	
	Preventive care/screening/immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	50% coinsurance	Preauthorization is required for complex / advanced imaging, including CT scans. For a Cost Waiver or Assistance on network providers for Lab, X ray, and Advanced Imaging, contact Covet: 1-909-315-4751
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.cap-rx.com	Generic drugs	0% coinsurance	Not covered	Covers up to a 30-90 day supply (retail prescription); 30 day supply (specialty drugs); 90 day supply (mail-order prescription).
	Preferred brand drugs	0% coinsurance	Not covered	
	Non-preferred brand drugs	0% coinsurance	Not covered	
	Specialty drugs	0% coinsurance	Not covered	Specialty Drugs may be sourced through an alternative sourcing program. Call Covet Health at +1 (909) 315-4751 to initiate the Specialty Drug process.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization , it may result in the denial of otherwise covered services.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	0% coinsurance		Non-Emergent Emergency Room Care: 50% coinsurance applies for Out-of-Network Provider.
	Emergency medical transportation	0% coinsurance	50% coinsurance	
	Urgent care	0% coinsurance	50% coinsurance	Non-Emergent Medical Transportation: 50% coinsurance applies for Out-of-Network Provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	Preauthorization is required.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Office Visit	0% coinsurance	50% coinsurance	Preauthorization is required for certain services.
	Outpatient services	0% coinsurance	50% coinsurance	
	Inpatient services	0% coinsurance	50% coinsurance	
If you are pregnant	Office visits	0% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services . Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	50% coinsurance	30 visits/year Precertification required.
	Rehabilitation services	0% coinsurance	50% coinsurance	20 visits/year. Includes Physical, Speech and Occupational therapies.
				Spinal Manipulation/Chiropractic care services limited to 12 visits per Plan Year.
				Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	0% coinsurance	50% coinsurance	Habilitation Services are covered for Mental Health conditions (Autism), limits are not applicable. Preauthorization is required.
	Skilled nursing care	0% coinsurance	50% coinsurance	30 visits/year Precertification required.
	Durable medical equipment	0% coinsurance	50% coinsurance	Preauthorization is required. For Assistance or a Cost Waiver please contact Covet: 1-909-315-4751
	Hospice services	0% coinsurance	50% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- | | | |
|--|--|--|
| <ul style="list-style-type: none">• Abortion (except in cases of rape, incest, medical complications, or when the life of the mother is endangered)• Acupuncture• Bariatric surgery• Cosmetic Surgery | <ul style="list-style-type: none">• Dental Care (Adult)• Hearing Aids• Infertility Treatment• Long Term Care• Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none">• Private-duty Nursing• Routine Eye Care (Adult)• Routine Foot Care• Weight Loss Programs |
|--|--|--|

Other Covered Services (This isn't a complete list. Check your policy or [plan](#) document for other covered services and your costs for these services.)

Chiropractic Care (limited to: 12 visits per year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-909-315-4751.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-909-315-4751.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-909-315-4751.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-909-315-4751.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The <u>plan's</u> overall <u>deductible</u>	\$5,000
<u>Specialist</u> coinsurance	0%
Hospital (facility) <u>coinsurance</u>	0%
Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$5,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,060

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The <u>plan's</u> overall <u>deductible</u>	\$5,000
<u>Specialist</u> coinsurance	0%
Hospital (facility) <u>coinsurance</u>	0%
Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$5,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$5,020

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The <u>plan's</u> overall <u>deductible</u>	\$5,000
<u>Specialist</u> coinsurance	0%
Hospital (facility) <u>coinsurance</u>	0%
Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
In this example, Mia would pay:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

The plan would be responsible for the other costs of these EXAMPLE covered services.