



Group Name: **Lorain City Schools**
Effective: **July 1, 2025 - June 30, 2026**

Premium Plan

Standard Plan

Basic Plan

Minimum Value Plan

Benefit Highlights & Premium Rates	\$500 PPO		\$750 PPO		\$1,750 Agg HDHP		\$3,750 PPO- ACA Plan	
Product / Network	SuperMed Plus		SuperMed Plus		SuperMed Plus		SuperMed Plus	
HSA Option	No		No		Yes		No	
Includes Major Med. Rx?	No		No		Yes		No	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Deductible Type	Embedded		Embedded		Aggregate		Embedded	
Single Deductible	\$500	\$1,500	\$750	\$2,000	\$1,750	\$4,000	\$3,750	\$4,000
Family Deductible	\$1,000	\$3,000	\$1,500	\$4,000	\$3,500	\$8,000	\$7,500	\$8,000
Employer Coinsurance % *	90%	60%	80%	60%	90%	60%	70%	50%
Single Out of Pocket (Excludes Deductible)	\$1,500	\$3,000	\$2,000	\$4,000	\$3,000	\$6,000	\$2,250	\$10,000
Family Out of Pocket (Excludes Deductible)	\$3,000	\$6,000	\$4,000	\$8,000	\$6,000	\$12,000	\$4,500	\$20,000
Single Maximum Out of Pocket	\$6,600	Unlimited	\$6,600	Unlimited	\$6,450	\$10,000	\$6,600	\$14,000
Family Maximum Out of Pocket	\$13,200	Unlimited	\$13,200	Unlimited	\$12,900	\$20,000	\$13,200	\$28,000
Office Visit	\$25	60% After Deductible	\$30	60% After Deductible	90% After Deductible	60% After Deductible	\$50	50% After Deductible
Specialist Office Visit	\$40	60% After Deductible	\$45	60% After Deductible	90% After Deductible	60% After Deductible	\$100	50% After Deductible
Urgent Care Office Visits	\$40	60% After Deductible	\$45	60% After Deductible	90% After Deductible	60% After Deductible	\$100	50% After Deductible
Emergency Room Visits**	\$100		\$150		90% After Deductible		\$300	
Inpatient Services	90% After Deductible	60% After Deductible	80% After Deductible	60% After Deductible	90% After Deductible	60% After Deductible	70% After Deductible	50% After Deductible
Prescription Drug Card Benefit Highlights	Rx card 1 \$10/\$25/\$50/\$60		Rx card 2 \$15/\$30/\$60/\$100		N/A		Rx card 3 \$10/\$50/\$100/\$200	
Single/Family Deductible	N/A		N/A		N/A		N/A	
	RETAIL		RETAIL		RETAIL		RETAIL	
Generic Copay	\$10.00		\$15.00		N/A		\$10.00	
Formulary Copay	\$25.00		\$30.00		N/A		\$50.00	
Non-Formulary Copay	\$50.00		\$60.00		N/A		\$100.00	
4th Tier Copay	\$60.00		\$100.00		N/A		\$200.00	
	MAIL		MAIL		MAIL		MAIL	
Generic Copay	\$20.00		\$30.00		N/A		\$20.00	
Formulary Copay	\$50.00		\$60.00		N/A		\$100.00	
Non-Formulary Copay	\$100.00		\$120.00		N/A		\$200.00	
4th Tier Copay	\$60.00		\$100.00		N/A		\$200.00	
	OTHER		OTHER		OTHER		OTHER	
Diabetic Supplies	Yes		Yes		N/A		Yes	
Comments								

Monthly Employee Costs

Single	\$196.51	\$138.38	\$75.40	\$0.00
Family	\$491.27	\$345.94	\$187.75	\$0.00