LORAIN CITY SCHOOLS

2025-2026 Benefits Overview

oswald
A UNISON RISK ADVISORS Company

We're giving you options!

1. Medical insurance coverage with Medical Mutual of Ohio – 4 plan options
2. Dental insurance coverage with Delta Dental - 2 plan options
3. Vision insurance coverage with Medical Mutual of Ohio – 1 plan option
4. Flexible Spending Accounts (FSA) and Dependent Care Accounts (DCA) with P&A Group

MEDICAL MUTUAL

DELTA DENTAL

eyeMed

2025 Medical Plans

MEDICAL MUTUAL®

BENEFIT HIGHLIGHTS	Lorain City Schools							
Plan Name	$500 PPO		$750 PPO		$1,750 HDHP		$3750 PPO ACA	
Product/Network	SuperMed Plus		SuperMed Plus		SuperMed Plus		SuperMed Plus	
BENEFIT SUMMARY	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**
Annual Deductible/Individual	$500	$1,500	$750	$2,000	$1,750	$4,000	$3,750	$4,000
Annual Deductible/Family	$1,000	$3,000	$1,500	$4,000	$3,500	$8,000	$7,500	$8,000
Coinsurance	10% After Deductible	40%, after Deductible	20% After Deductible	40% After Deductible	10% Afrter Deductible	40% After Deductible	30% After Deductible	50% After Deductible
Office Visit/Exam	$25 Copay	40%, after Deductible	$30 Copay	40% After Deductible	10% Afrter Deductible	40% After Deductible	$50 Copay	50% After Deductible
Outpatient Specialist Visit	$40 Copay		$45 Copay	40% After Deductible	10% Afrter Deductible	40% After Deductible	$100 Copay	50% After Deductible
Annual Out-of-Pocket Limit/Individual	$6,600	Unlimited	$6,600	Unlimited	$6,450	$10,000	$6,600	$14,000
Annual Out-of-Pocket Limit/Family	$13,200	Unlimited	$13,200	Unlimited	$12,900	$12,000	$13,200	$28,000
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
Deductible Embedded	Yes		Yes		N/A		Yes	
Inpatient Hospital Services	10% After Dedcutible	40% After Deductible	20% After Deductible	40% After Deductible	10% Afrter Deductible	40% After Deductible	30% After Deductible	50% After Deductible
Surgical Services	10% After Dedcutible	40% After Deductible	20% After Deductible	40% After Deductible	10% Afrter Deductible	40% After Deductible	30% After Deductible	50% After Deductible
Emergency Services	$100 Copay		$150 Copay		10% After Deductible		$300 Copay	
Urgent Care	$40 Copay	40% After Deductible	$45 Copay	40% After Deductible	10% Afrter Deductible	40% After Deductible	$100 Copay	50% After Deductible
Prescription Drug Benefits								
Prescription Drug Deductible	N/A		N/A		N/A		N/A	
Retail								
Generic / Tier 1	$10 Copay		$15 Copay		N/A		$10 Copay	
Brand (Formulary/Preferred) / Tier 2	$25 Copay		$30 Copay		N/A		$50 Copay	
Brand (Non-Formulary/Non-preferred) / Tier 3	$50 Copay		$60 Copay		N/A		$100 Copay	
Specialty / Tier 4	$60 Copay		$100 Copay		N/A		$200 Copay	
Mail Order								
Generic / Tier 1	$20 Copay		$30 Copay		N/A		$20 Copay	
Brand (Non-Formulary/Non-preferred) / Tier 3	$100 Copay		$60 Copay		N/A		$100 Copay	
Brand (Non-Formulary/Non-preferred) / Tier 3	$100 Copay		$120 Copay		N/A		$200 Copay	
Specialty / Tier 4	$ 60 Copay		$100 Copay		N/A		$200 Copay	
Diabetic Supplies	Yes		Yes		N/A		Yes	

This is an illustration of In-Network benefits, but please note that these plans also provide coverage outside of the network.
Please refer to the plan documents for details & final confirmation of coverage.

Dental & Vision

DENTAL

BENEFITS	Dental A		Dental B	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (Single/Family)	N/A	N/A	N/A	N/A
Annual Maximum	$1,700	$1,200	$1,000	$500
Preventive & Diagnostic	100%	100%	100%	100%
Basic Services	80%	60%	80%	60%
Major Services	80%	60%	80%	60%
Orthodontia	100%	100%	100%	100%
Orthodontia Lifetime Maximum	$1,000	$1,000	$1,000	$1,000

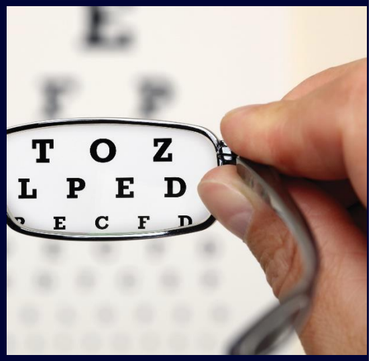
- Two dental plan options
- Access to the largest network of dentists in the U.S.
- www.deltadentaloh.com

DELTA DENTAL®

VISION

BENEFITS	VSP Full Feature	
	In-Network	Out-of-Network
Eye Exam	$15 Copay	Up to $39
Lenses	$15 Copay	Up to $30
Frames	$0 Copay w/ $100 allowance + 20%	Up to $50
Contacts – Medically Necessary	$0 Copay	Up to $210
Contacts – Elective	$0 Copay w/ $100 allowance + 20%	Up to $80
Exam Frequency	Calendar Year	
Lens Frequency	Calendar Year	
Frame Frequency	Every Other Calendar Year	

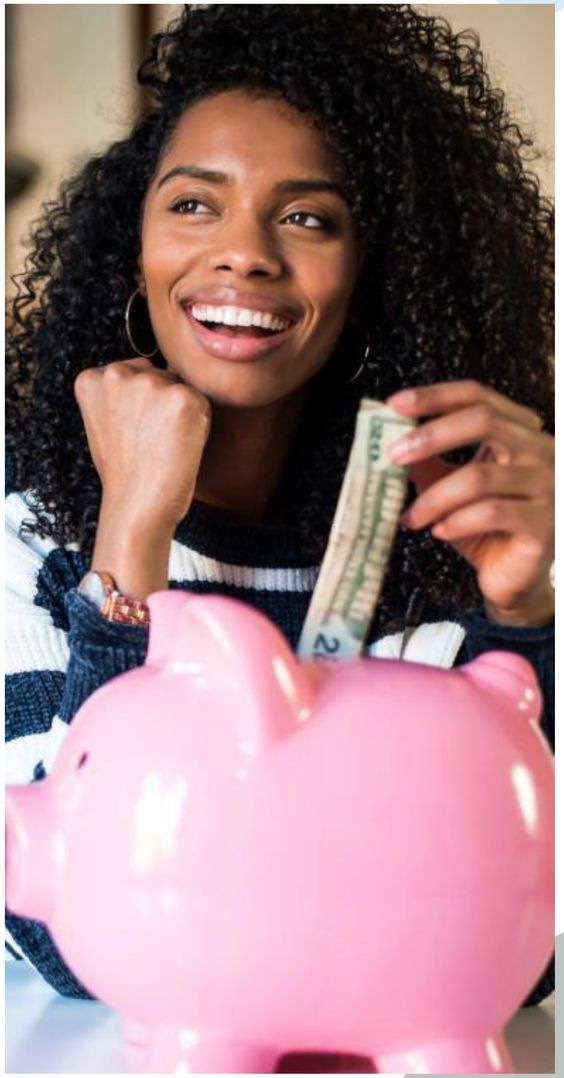




- Access to over 4,000 optometrists and ophthalmologists in the EyeMed network.
- www.medmutual.com

MEDICAL MUTUAL®

Flexible Spending Accounts and Dependent Care Accounts



A flexible spending Account (FSA) allows you to set aside a portion of your pretax pay to use for medical, dental, and vision costs that are not covered by insurance, or only partially covered. A Dependent Care Account (DCA) allows you to set aside a portion of your pretax pay for childcare/elder care expenses. Because it is deducted from your pay before taxes, you can save up to 30% on your dollar (depending on your tax bracket)! Estimate how much you usually spend on these types of expenses in a year and set aside that dollar amount into your FSA or DCA.

Health Flex Spending Account

Covers the cost of medical, dental, and vision expenses incurred by you and or your eligible dependent(s). Eligible expenses include deductibles, co-pays, prescriptions, eyeglasses, and dental work.

Maximum election amount: $3,300

Dependent Care Assistance Account

Covers the amount you pay to daycare centers, babysitters, after school programs, day camp programs and eldercare facilities.

This account does NOT reimburse medical expenses for your dependent(s). It is for qualified daycare expenses only.

Maximum election amount: $5,000

P&A GROUP EST. 1975

FSA Eligible Expense List

- Alcoholism Treatment
- Ambulance
- Anesthetists
- Arch Supports
- Artificial Limbs
- Blood Tests
- Braces
- Contact Lenses
- Chiropractic Visits
- Crutches
- Dental Treatments
- Dentures
- Dermatologist Visits



- Diagnostic Testing
- Drug Addiction Therapy
- Eyeglasses
- Hospital Bills
- Hearing Aides
- Insulin Treatments
- Lab Tests
- Operating Room Costs
- Oral Surgery
- Organ Transplant
- Orthopedic Shoes
- Oxygen & equipment
- Physician Services
- Physiotherapist Services
- Postnatal Treatments
- Prenatal Care
- Prescription Drugs
- Psychiatrist Services
- Psychologist Services



- Spinal Fluid Test
- Splints
- Sterilization
- Therapy Equipment
- Vaccines
- Vasectomy
- Vitamins (if prescribed)
- Wheelchairs
- X-Rays

This is just a partial list of the eligible HSA expenses. Please visit the IRS website & Publication 502 for a complete listing.

AllOne Health - Employee Assistance Program

Need someone to talk to?

FREE resources are available to you and are completely CONFIDENTIAL.

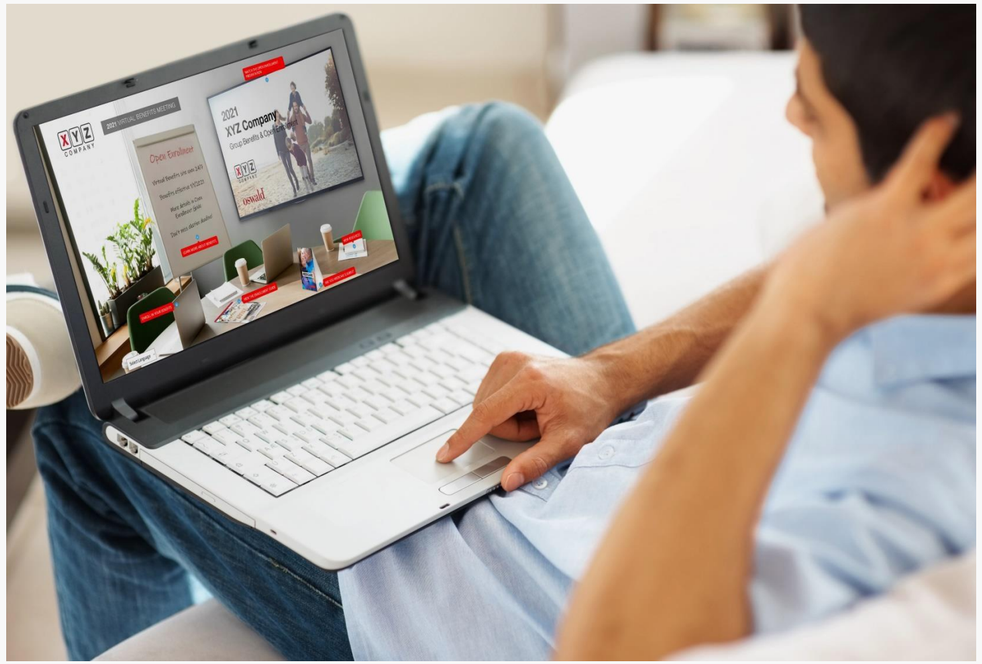
- Available by phone 24/7
- 6 Mental Health Sessions
- Medical Advocacy
- Personal Assistant
- Legal Referrals
- Financial Consultation
- Work-Life Resources and Referrals



1.800.227.6007

24/7 Support, Resources & Information

What do I need to do now?



For additional information on your benefits and to enroll, visit the Benefits Website at https://lcsbenefits.org/







Open Enrollment happens once per year & is the only time you can make changes to your plans without a Qualifying Event. If you do experience a Qualifying Event during the year,
be sure to notify the Benefits Office within 30 days.