

# Lake Forest Academy

## Benefit Contributions 2023-2024

### Medical - Blue Cross Blue Shield

#### BCBS HMO Advantage MIBAH2020

	Monthly Premiums Per Employee	LFA Monthly Contribution Per Employee	Employee Monthly Contribution	Employee Cost per Payperiod (24)
Employee Only	\$809.25	\$809.25	\$0.00	\$0.00
Family with 2 Employees	\$2,466.14	\$2,466.14	\$0.00	\$0.00
Employee & Child(ren)	\$1,585.55	\$1,535.55	\$50.00	\$25.00
Employee & Spouse	\$1,689.84	\$1,614.84	\$75.00	\$37.50
Employee & Family	\$2,466.14	\$2,196.14	\$270.00	\$135.00

#### BlueEdge HSA MIEEA2030 - \$2,500/\$5,000 Deductible Plan

	Monthly Premiums Per Employee	LFA Monthly Contribution Per Employee	Employee Monthly Contribution	Employee Cost per Payperiod (24)	LFA Annual HSA Contribution
Employee Only	\$819.92	\$809.92	\$10.00	\$5.00	\$1,500
Family with 2 Employees	\$2,498.70	\$2,438.70	\$60.00	\$30.00	\$3,000
Employee & Child(ren)	\$1,606.47	\$1,369.47	\$237.00	\$118.50	\$2,500
Employee & Spouse	\$1,712.15	\$1,408.15	\$304.00	\$152.00	\$2,500
Employee & Family	\$2,498.70	\$1,974.70	\$524.00	\$262.00	\$2,500

#### BlueEdge HSA MPS91605 - \$1,500/\$3,000 Deductible Plan

	Monthly Premiums Per Employee	LFA Monthly Contribution Per Employee	Employee Monthly Contribution	Employee Cost per Payperiod (24)	LFA Annual HSA Contribution
Employee Only	\$954.71	\$809.71	\$145.00	\$72.50	\$1,000
Family with 2 Employees	\$2,909.45	\$2,439.45	\$470.00	\$235.00	\$2,000
Employee & Child(ren)	\$1,870.55	\$1,370.55	\$500.00	\$250.00	\$1,500
Employee & Spouse	\$1,993.60	\$1,408.60	\$585.00	\$292.50	\$1,500
Employee & Family	\$2,909.45	\$1,974.45	\$935.00	\$467.50	\$1,500

### Dental Insurance - Guardian

	Monthly Premiums Per Employee	LFA Monthly Contribution Per Employee	Employee Monthly Contribution	Employee Cost per Payperiod (24)
Employee Only	\$50.00	\$50.00	\$0.00	\$0.00
Family	\$140.00	\$70.00	\$70.00	\$35.00

### Vision Insurance - VSP

	Monthly Premiums	Annual Premium	Deduction per Payperiod (24)
Employee Only	\$8.77	\$105.24	\$4.39
Employee & One	\$14.02	\$168.24	\$7.01
Employee & Children	\$14.32	\$171.84	\$7.16
Employee & Family	\$23.08	\$276.96	\$11.54

### Allstate Identity Protection

	Monthly Premiums	Annual Premium	Deduction per Payperiod (24)
Employee Only	\$10.00	\$120.00	\$5.00
Family	\$18.00	\$216.00	\$9.00



# LFA Blue Cross Blue Shield Medical Plans at a Glance

The following outlines benefits for LFA medical plans and shows the amounts YOU PAY for covered services after you meet the annual deductible (unless otherwise noted).

	BlueEdge HSA MIEEA2030 - \$2,500 Plan		BlueEdge HSA MPS91605 - \$1,500 Plan		BCBS HMO Advantage MIBAH2020	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
<b>LFA contribution to Health Savings Account (HSA)</b>	\$1,500 individual annually (\$750/six months) \$2,500 family annually (\$1,250/six months) \$3,000 2EE family annually (\$1,500/six months)		\$1,000 individual annually (\$500/six months) \$1,500 family annually (\$750/six months) \$2,000 2EE family annually (\$1,000/six months)		HMO plans are not eligible for HSA participation	
<b>Annual deductible</b> <sup>4,5</sup>	\$2,500 individual \$5,000 family	\$5,000 individual \$10,000 family	\$1,500 individual \$3,000 family	\$1,500 individual \$3,000 family	\$0	\$0
<b>Out-of-pocket limits</b>	\$5,000 individual \$7,350 family	\$15,000 individual \$22,050 family	\$3,000 individual \$6,000 family	\$3,000 individual \$6,000 family	\$1,500 individual \$3,000 family	\$1,500 individual \$3,000 family
<b>Office visit</b>						
• Primary care	20%	40%	\$0 after deductible	20%	\$20/visit	Not Covered
• Specialist	20%	40%	\$0 after deductible	20%	\$40/visit	Not Covered
<b>Preventive care, screenings &amp; immunizations</b>	No charge	No charge	No charge	No charge	No Charge	Not Covered
<b>Inpatient hospital</b>						
• Facility fee, physician fee	20%	\$300/visit + 40%	\$0 after deductible	20%	No Charge	Not Covered
<b>Outpatient surgery</b>						
• Facility fee, physician fee	20%	40%	\$0 after deductible	20%	No Charge	Not Covered
<b>Emergency room</b>	20%	20%	10%	20%	\$250/visit	Not Covered
<b>X-ray and lab</b>	20%	40%	\$0 after deductible	20%	No Charge	Not Covered
<b>Chiropractic</b>	20% up to 30 visits annual max	40% up to 30 visits annual max	20% up to 30 visits annual max	40% up to 30 visits annual max	\$40/visit	Not Covered
<b>Prescription drugs</b>						
<b>Retail (30-day supply)</b>						
• Generic	10%	20%	20%	20%	No Charge	Not Covered
• Generic non-preferred					\$10	Not Covered
• Brand preferred	20%	20%	20%	20%	\$50	Not Covered
• Brand non-preferred	30%	30%	20%	20%	\$100	Not Covered
<b>Home Delivery (90-day supply)</b>						
• Generic					No Charge	Not Covered
• Generic non-preferred	10%	20%	20%	20%	\$20	Not Covered
• Brand preferred	20%	20%	20%	20%	\$100	Not Covered
• Brand non-preferred	30%	30%	20%	20%	\$200	Not Covered
<b>Specialty</b>						
• Preferred	40%	40%	20%	20%	\$150	Not Covered
• Non-preferred	50%	50%	20%	20%	\$250	Not Covered