A Comparison of Your 2016 LMU **mybenefits**

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OVERVIEW OF YOUR MEDICAL OPTIONS (Refer to your EOC or SPD for plan details.)

Plan Features	Anthem Blue Cross PPO		Anthem Blue Cross HealthSave		Anthem Blue Cross HMO	Kaiser Permanente HMO
	In-Network	Out-of-Network	In-Network	Out-of-Network		
Health Savings Account (HSA)	Not Available		Annual LMU Contribution to Your HSA: Employee Only: $500 Other Coverage Levels: $2,000 (you may contribute an additional amount up to IRS limits)		Not Available	Not Available
Deductible	$500 per person[1] $1,000 per family[1]	$750 per person[1] $1,200 per family[1]	$2,500 per person/$5,000 per family[1]		$150 per person[1] $300 per family[1]	$150 per person[1] $300 per family[1]
Out-of-pocket maximum	$2,500 per person, including deductible[1,2] $5,000 per family, including deductible[1,2]	$5,000 per person, including deductible[1,2] $10,000 per family, including deductible[1,2]	$3,400 per person, including deductible[1,2] $6,800 per family, including deductible[1,2]	$7,000 per person, including deductible[1,2] $14,000 per family, including deductible[1,2]	$1,500 per person[1,2] $4,500 per family[1,2]	$1,500 per person[1,2] $4,500 per family[1,2]
Physician's fees						
> Primary care office visits	$20 copayment	You pay 40% after deductible	You pay 20% after deductible	You pay 40% after deductible	$20 copayment	$20 copayment
> Specialist office visits	$30 copayment	You pay 40% after deductible	You pay 20% after deductible	You pay 40% after deductible	$30 copayment	$30 copayment
> Hospital visits	You pay 20% after deductible	You pay 40% after deductible	You pay 20% after deductible	You pay 40% after deductible	No charge	$20 copayment
Preventive care						
> Physical exams	No charge (deductible is waived)	You pay 40% after deductible	No charge	You pay 40% after deductible	No charge	No charge
> Immunizations	No charge (deductible is waived)	You pay 40% after deductible	No charge	You pay 40% after deductible	No charge	No charge
> Well-child care	No charge (deductible is waived) (through age 6)	You pay 40% after deductible	No charge	You pay 40% after deductible	No charge	No charge (age 23 months or younger)
> Well-woman care	No charge (deductible is waived)	You pay 40% after deductible	No charge	You pay 40% after deductible	No charge	No charge
Emergency care	You pay 20% after the deductible and after you pay $100 copayment (waived if admitted)		You pay 20% after deductible	You pay 20% after deductible	$100 copayment (waived if admitted)	$100 copayment (waived if admitted)

[1]Effective January 1, 2016 through December 31, 2016.
[2]After you pay this amount, the plan pays 100% of most covered expenses for the remainder of the year. Under the Anthem Blue Cross PPO, HealthSave and HMO plans and the Kaiser Permanente HMO plan, infertility services do not apply toward satisfaction of the out-of-pocket maximum.

Plan Features	Anthem Blue Cross PPO		Anthem Blue Cross HealthSave		Anthem Blue Cross HMO	Kaiser Permanente HMO
	In-Network	Out-of-Network	In-Network	Out-of-Network		
Inpatient hospital	You pay 20% after deductible	You pay 40% after deductible and after you pay $500 inpatient deductible	You pay 20% after deductible	You pay 40% after deductible	$250 copayment per admission	$250 copayment per admission
Surgery	You pay 20% after deductible	You pay 40% after deductible	You pay 20% after deductible	You pay 40% after deductible	Inpatient: No charge Outpatient: No charge	Inpatient: $250 copayment Outpatient: $30 copayment
Diagnostic X-ray and lab tests	You pay 20% after deductible	You pay 40% after deductible	You pay 20% after deductible	You pay 40% after deductible	No charge	No charge
Mental and nervous disorders						
> Inpatient	You pay 20% after deductible	You pay 40% after deductible and after you pay $500 inpatient deductible	You pay 20% after deductible	You pay 40% after deductible	$250 copayment per admission	$250 copayment per admission
> Outpatient	$20 copayment; pre-service review required	You pay 40% after deductible; pre-service review required	You pay 20% after deductible	You pay 40% after deductible	$20 copayment; pre-service review required	$20 copayment
Substance abuse > Inpatient	You pay 20% after deductible	You pay 40% after deductible and after you pay $500 inpatient deductible	You pay 20% after deductible	You pay 40% after deductible	$250 copayment per admission	$250 copayment (detox only) $100 copayment for residential recovery services
> Outpatient	$20 copayment; pre-service review required	You pay 40% after deductible; pre-service review required	You pay 20% after deductible	You pay 40% after deductible	$20 copayment; pre-service review required	$20 copayment $5 copayment for group therapy

Plan Features	Anthem Blue Cross PPO		Anthem Blue Cross HealthSave		Anthem Blue Cross HMO	Kaiser Permanente HMO
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**		
Prescription drug					**In-network benefits only:**	**Kaiser pharmacy:**
> Retail pharmacy[3]	Up to a 30-day supply	Up to a 30-day supply	Up to a 30-day supply	Up to a 30-day supply	Up to a 30-day supply	Up to a 30-day supply
> Generic	$10 copayment	$10 copayment[4]	Tier 1: $10 copayment, after deductible	All Tiers: 30% of the prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount (compound drugs and specialty pharmacy drugs not covered)	$10 copayment	$10 copayment
> Brand name formulary	$25 copayment	$25 copayment[4]	Tier 2: $30 copayment, after deductible		$25 copayment	$25 copayment
> Brand name non-formulary	$50 copayment	$50 copayment[4]	Tier 3: $50 copayment, after deductible		$50 copayment	$25 copayment
> Compound drugs	$50 copayment	$50 copayment[4]	Tier 4: 30% of maximum allowed amount (after deductible)		$50 copayment	$25 copayment
> Self-administered injectable drugs, except insulin	20% of prescription drug maximum allowed amount (maximum $100 copayment)	Not covered	You pay the full price for prescription drugs (except certain preventive care drugs) until you meet the annual deductible. Once you meet the deductible, you pay the applicable copayment.		20% of prescription drug maximum allowed amount (maximum $100 copayment)	No charge
> Mail order[3]	Up to a 90-day supply		Up to a 90-day supply		Up to a 90-day supply	Up to a 100-day supply
> Generic	$20 copayment	Not covered	Tier 1: $10 copayment (deductible waived)	Not covered	$20 copayment	$20 copayment
> Brand name formulary	$50 copayment	Not covered	Tier 2: $60 copayment, after deductible	Not covered	$50 copayment	$50 copayment
> Brand name non-formulary	$100 copayment	Not covered	Tier 3: $100, after deductible Tier 4: 30% of prescription drug maximum allowed amount You pay the full price for prescription drugs (except certain preventive care drugs) until you meet the annual deductible. Once you meet the deductible, you pay the applicable copayment.	Not covered	$100 copayment	$50 copayment
> Impotence	Impotence drugs are covered, subject to preauthorization.					You pay 50%

[3]Prescription drug copayments do not apply toward the deductible but do count toward the out-of-pocket maximum.
[4]In addition to the copayment, you are responsible for paying 50% of the remaining covered expense plus any amount over the allowed amount.

OVERVIEW OF YOUR DENTAL OPTIONS

Plan Features	Delta Dental PPO		DeltaCare® USA[2]
	In-Network	Out-of-Network	
Deductible[1]	$25 per person/$75 per family		None
Maximum benefit[1]	$1,500 per person. Fees for diagnostic or preventive services do not count toward maximum.	$1,500 per person	No maximum
Typical covered expenses			
> Routine exams and cleanings	100% (deductible is waived)	80% (deductible is waived)	No charge
> X-rays	100% (deductible is waived)	80% (deductible is waived)	No charge
> Regular fillings	100%	80%	No charge
> Root canals	100%	80%	Up to $220 copayment per canal
> Bridges and crowns	50%	50%	Up to $195 copayment per unit (depending on service completed)
> Dentures	50%	50%	Up to $170 copayment each
> Orthodontia	50%, up to $1,000 per lifetime per child (for children up to age 26 only)		$1,700 per dependent to age 19 (beyond 24 months, an additional fee may apply) $1,900 per dependent ages 19–26 or adult (beyond 24 months, an additional fee may apply)

[1] Effective January 1, 2016 through December 31, 2016.
[2] Please see your DeltaCare USA Description of Benefits and Copayments for details.

OVERVIEW OF YOUR VISION BENEFITS

Plan Features	If you see a VSP doctor, the plan pays...	If you see a non-VSP doctor, the plan pays...
Eye exams (once every calendar year)	100% after a $10 copayment	Up to $45 after a $10 copayment
Frames (once every calendar year)	Up to $150 allowance; up to $80 allowance at Costco	Up to $70 after a $25 copayment
Lenses (once every calendar year)		
> Single vision	100% after a $25 copayment (combined frames and lenses copayment)	$30 per pair after a $25 copayment
> Bifocal		$50 per pair after a $25 copayment
> Trifocal		$65 per pair after a $25 copayment
> Lenticular		$100 per pair after a $25 copayment
> Contact lenses (once every calendar year; instead of a complete pair of prescription glasses)	Up to $150 allowance toward fitting, evaluation and materials, after a $60 copayment	Up to $105 allowance toward fitting, evaluation and materials

LMU BENEFITS HIGHLIGHTS

Each pay period, LMU will pay all or a portion of the cost for the benefits you elect. LMU will cover:

- **100% of the cost of employee-only coverage under the Delta Dental PPO/ Vision Coverage plan or 100% of the cost of the DeltaCare USA/Vision Coverage plan for all levels of coverage**
- **100% of the cost of long-term disability (LTD) benefits that could replace up to 60% of your monthly base salary**
- **100% of the cost of 1x your annual salary (with a coverage of minimum $50,000/maximum of $300,000) in basic life insurance, and 1x your annual salary (with a coverage of minimum $50,000/maximum $300,000) in basic accidental death and dismemberment (AD&D) insurance for yourself (please designate a beneficiary)**
- **100% of the cost of $200,000 of business travel accident (BTA) insurance**

When you elect medical coverage, you will pay a percentage of the total premium cost based on your salary, and LMU will cover the remainder of the cost of your coverage.

This overview is intended only to provide a brief summary of your medical, dental and vision options. If there is a discrepancy between these charts and the official plan documents, the official plan documents will govern.