A Comparison of Your 2017 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 $1,000 per family	$1,000 per person $2,000 per family	$2,600 per person/$5,200 per family[1]		$250 per person $500 per family	$250 per person $500 per family
Out-of-pocket maximum	$3,000 per person, including deductible[1,2] $6,000 per family, including deductible[1,2]	$6,000 per person, including deductible[1,2] $12,000 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[2] $4,500 per family[2]	$1,500 per person[2] $4,500 per family[2]
Office visits						
> Primary care	$20 copayment (deductible waived)	You pay 40% after deductible	You pay 20% after deductible	You pay 40% after deductible	$20 copayment	$20 copayment after deductible
> Specialists	$30 copayment (deductible waived)	You pay 40% after deductible	You pay 20% after deductible	You pay 40% after deductible	$30 copayment	$30 copayment after deductible
Preventive care						
> Physical exams	No charge (deductible is waived)	Not covered	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% (deductible is waived)	No charge	You pay 40% after deductible	No charge	No charge
Emergency care	You pay 20% after you pay $100 deductible (deductible waived if admitted)		You pay 20% after deductible	You pay 20% after deductible	$100 per visit after deductible	$100 per visit after deductible (waived if admitted)

[1]The family amount includes insured employee and one or more members of the employee's family. After one person reaches the in-network individual maximum deductible, that person will pay coinsurance for care; if they reach the individual out-of-pocket limit, the plan will pay 100% for that person for the rest of the year. All other family members will pay the full cost of care until the in-network family deductible is met and will pay coinsurance until the in-network family out-of-pocket maximum is met.

[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 $200, then 20% after deductible	You pay 40% after deductible and after you pay $500 inpatient deductible[1]	You pay 20% after deductible	You pay 40% after deductible (to a $1,000 per day maximum)	$250 copayment per admission after deductible	$250 copayment per admission after deductible
Surgery	You pay 20% after deductible	You pay 40% after deductible (to a $350 per day maximum)	You pay 20% after deductible	You pay 40% after deductible (to a $350 per day maximum)	Inpatient: $250 per admission after deductible Outpatient: $100 per admission after deductible	Inpatient: $250 copayment after deductible Outpatient: $100 per procedure after deductible
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 $200, then 20% after deductible	You pay 40% after deductible and after you pay $500 inpatient deductible[1]	You pay 20% after deductible	You pay 40% after deductible (to a $1,000 per day maximum)	$250 copayment per admission after deductible	$250 copayment per admission after deductible
> Outpatient Facility Care	You pay 20% after deductible	You pay 40% after deductible	You pay 20% after deductible	You pay 40% after deductible (to a $350 per day maximum)	No charge	You pay $20 per visit after deductible; You pay $10 after deductible for group therapy
> Office Visit	You pay $20 per visit (deductible waived, pre-service review required)	You pay 40% after deductible (pre-service review required)	You pay 20% after deductible	You pay 40% after deductible	You pay $20 per visit (requires pre-service review)	N/A
Substance abuse						
> Inpatient	You pay $200, then 20% after deductible	You pay 40% after deductible and after you pay $500 inpatient deductible[1]	You pay 20% after deductible	You pay 40% after deductible (to a $1,000 per day maximum)	$250 copayment per admission after deductible	$250 per admission after deductible (detox only) $100 copayment for residential recovery services
> Outpatient Facility Care	You pay 20% after deductible	You pay 40% after deductible	You pay 20% after deductible	You pay 40% after deductible (to a $350 per day maximum)	No charge	$20 copayment per visit after deductible $5 copayment after deductible for group therapy
> Outpatient Office Visit	You pay $20 per visit (deductible waived, pre-service review required)	You pay 40% after deductible (pre-service review required)	You pay 20% after deductible	You pay 40% after deductible	You pay $20 per visit (requires pre-service review)	N/A

[1]Utilization review required, if not obtained an additional $500 deductible is required.

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[1]	Up to a 30-day supply	Up to a 30-day supply	Female oral contraceptives: No charge	Up to a 30-day supply	Up to a 30-day supply	Up to a 30-day supply
> Generic	$10 copayment	$10 copayment plus 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount	Tier 1: $10 copayment, after deductible Tier 2: $30 copayment, after deductible Tier 3: $50 copayment, after deductible Tier 4: 30% of maximum allowed amount (max $150 per refill after deductible) 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.	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 plus 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount			$25 copayment	$25 copayment
> Brand name non-formulary	$50 copayment	$50 copayment plus 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount			$50 copayment	$25 copayment
> Compound drugs	$50 copayment	Not covered			$50 copayment	$25 copayment
> Self-administered injectable drugs, except insulin	20% of prescription drug maximum allowed amount (maximum $100 copayment)	Not covered			20% of prescription drug maximum allowed amount (maximum $100 copayment)	No charge

[1]Prescription drug copayments do not apply toward the deductible but do count toward 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**		
> Mail order[1]	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	Female oral contraceptives: No charge	Not covered	$20 copayment	$20 copayment
> Brand name formulary	$50 copayment	Not covered	Tier 1: $10 copayment (deductible waived)	Not covered	$50 copayment	$50 copayment
> Brand name non-formulary	$100 copayment	Not covered	Tier 2: $60 copayment, after deductible Tier 3: $100 copayment, after deductible Tier 4: 30% of prescription drug maximum allowed amount (max $300 per refill)	Not covered	$100 copayment	$50 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.	Not covered	20% of prescription drug maximum allowed amount (maximum $100 copayment)	Not covered

[1]Prescription drug copayments do not apply toward the deductible but do count toward the out-of-pocket maximum.

OVERVIEW OF YOUR DENTAL OPTIONS

Plan Features	Delta Dental PPO		DeltaCare® USA[1]
	In-Network	Out-of-Network	
Deductible	$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 (porcelain and resin-based composite fillings are extra)
> Root canals	100%	80%	Up to $205 copayment per canal; up to $220 copayment for re-treatment of a root 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 up to age 19 (beyond 24 months, an additional fee may apply) $1,900 per dependent up to ages 19–26 or adult (beyond 24 months, an additional fee may apply)

[1] 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)	$80 for Costco frames $150 allowance for wide selection of frames $170 for featured frames Plus 20% savings on the amount over allowance	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
> Contact lenses (once every calendar year; instead of a complete pair of prescription glasses)	Up to $150 allowance for contact lenses $60 copayment for fitting, evaluation and materials	Up to $105 allowance toward fitting, evaluation and materials, after a $60 copayment

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 minimum coverage of $50,000/maximum of $300,000) in basic life insurance and 1x your annual salary (with a minimum coverage of $50,000/maximum of $300,000) in basic accidental death and dismemberment (AD&D) insurance for yourself (please make sure to 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.