

# A Comparison of YOUR LMU BENEFITS

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

Plan Features	Anthem Blue Cross PPO		Anthem Blue Cross HMO	Kaiser Permanente HMO
	In-Network	Out-of-Network		
<b>Deductible</b>	\$250 per person/\$500 per family <sup>1</sup>		None	None
<b>Out-of-pocket maximum</b>	\$2,000 per person (plus deductible) <sup>1,2</sup> \$4,000 per family (plus deductible) <sup>1,2</sup>	\$4,000 per person (plus deductible) <sup>1,2</sup> \$8,000 per family (plus deductible) <sup>1,2</sup>	\$1,000 per person <sup>1,2</sup> \$2,000 per family <sup>1,2</sup>	\$1,500 per person <sup>2</sup> per calendar year \$3,000 per family <sup>2</sup> per calendar year
<b>Lifetime maximum</b>	No maximum <sup>3</sup>		No maximum	No maximum
<b>Physician's fees</b>				
> Office visits	\$20 copayment	Plan pays 60%	\$20 copayment	\$20 copayment
> Hospital visits	Plan pays 80%	Plan pays 60%	No charge	No charge
<b>Preventive care</b>	(Copayments do not count toward the deductible) \$20 copayment; deductible is waived	Not covered	No charge (age limits do not apply)	\$20 copayment (age limits do not apply)
> Physical exams (age 7 and older)				
> Immunizations (through age 6)	No charge	Plan pays 60%; limited to \$12 per immunization	No charge (age limits do not apply)	No charge (age limits do not apply)
> Well-child care (through age 6)	\$20 copayment; deductible is waived	Plan pays 60%; limited to \$20 per exam	No charge (age limits do not apply)	\$5 copayment (age 23 months or younger)
<b>Emergency care</b>	Plan pays 80% after the deductible and after you pay \$100 copayment; waived if admitted	Plan pays 60% after the deductible and after you pay \$500 inpatient deductible	\$100 copayment; waived if admitted	\$100 copayment; waived if admitted
<b>Inpatient hospital</b>	Plan pays 80%	Plan pays 60% after the deductible and after you pay \$500 inpatient deductible	\$250 copayment per stay	\$250 copayment per stay
<b>Surgery</b>	Plan pays 80%	Plan pays 60%	Inpatient: \$250 copayment Outpatient: No charge	Inpatient: \$250 copayment Outpatient: \$20 copayment
<b>Diagnostic X-ray and lab tests</b>	Plan pays 80%	Plan pays 60%	No charge	No charge
<b>Mental and nervous disorders</b>				
> Inpatient	Plan pays 80%	Plan pays 60% after the deductible and after you pay \$500 inpatient deductible	\$250 copayment per stay	\$250 copayment
> Outpatient	\$20 copayment; pre-service review required after 12th visit	Plan pays 60%; pre-service review required after 12th visit	\$20 copayment; pre-service review required after 12th visit	\$20 copayment
<b>Substance abuse</b>				
> Inpatient	Plan pays 80%	Plan pays 60% after the deductible and after you pay \$500 inpatient deductible	\$250 copayment per stay	\$250 copayment (detox only) \$100 copayment for residential recovery services
> Outpatient	\$20 copayment; pre-service review required after 12th visit	Plan pays 60%; pre-service review required after 12th visit	\$20 copayment; pre-service review required after 12th visit	\$20 copayment \$5 copayment for group therapy
<b>Prescription drug</b>			<b>In-network benefits only:</b>	<b>Kaiser pharmacy:</b>
> Retail pharmacy <sup>4</sup>	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 <sup>5</sup>	\$10 copayment	\$10 copayment
> Brand name	\$20 copayment	\$20 copayment <sup>5</sup>	\$20 copayment	\$20 copayment
> Brand name non-formulary	\$35 copayment	\$35 copayment <sup>5</sup>	\$35 copayment	\$20 copayment
> Mail order <sup>4</sup>	Up to a 90-day supply	Not covered	Up to a 90-day supply	Up to a 100-day supply
> Generic	\$20 copayment	Not covered	\$20 copayment	\$20 copayment
> Brand name	\$40 copayment	Not covered	\$40 copayment	\$40 copayment
> Brand name non-formulary	\$70 copayment	Not covered	\$70 copayment	\$40 copayment
> Impotence	Not covered	Not covered	Not covered	50% copayment

<sup>1</sup> Effective June 1, 2010 through December 31, 2011.

<sup>2</sup> After you pay this amount, the plan pays 100% of most covered expenses for the remainder of the year. Under the Anthem Blue Cross HMO, infertility services also do not apply.

<sup>3</sup> Effective January 1, 2011.

<sup>4</sup> Prescription drug copayments do not apply toward the deductible or out-of-pocket maximum.

<sup>5</sup> 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 <sup>®</sup> USA <sup>2</sup>
	In-Network	Out-of-Network	
Deductible	\$25 per person/\$75 per family <sup>1</sup>		None
Maximum benefit	\$1,500 per person <sup>1</sup>		No maximum
<b>Typical Covered Expenses</b>			
Routine exams and cleanings	100%	80%	No charge
X-rays	100%	80%	No charge
Regular fillings	100%	80%	No charge
Root canals	100%	80%	Up to \$220 copayment per canal
Bridges and crowns	50%	50%	\$25–\$220 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 19 only)		\$1,700 per child (24-month limited benefit) \$1,900 per adult (24-month limited benefit)

<sup>1</sup> Effective June 1, 2010 through December 31, 2011.

<sup>2</sup> Please see your Delta Dental Patient Charge Schedule 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 12 months)	100% after a \$10 copayment	Up to \$45 after a \$10 copayment
Frames (once every 12 months)	Up to \$120 allowance	Up to \$47 after a \$25 copayment
<b>Lenses (once every 12 months)</b>		
> Single vision	100% after a \$25 copayment (combined frames and lenses copayment)	\$45 per pair after a \$25 copayment
> Bifocal		\$65 per pair after a \$25 copayment
> Trifocal		\$85 per pair after a \$25 copayment
> Lenticular		\$125 per pair after a \$25 copayment
> Contact lenses (once every 12 months; instead of a complete pair of prescription glasses)	Up to \$120 allowance toward fitting, evaluation, and materials	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 plan or 100% of the cost of the DeltaCare USA 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 \$50,000 in life insurance and \$50,000 in accidental death and dismemberment (AD&D) insurance for yourself; and

- > 100% of the cost of \$200,000 of business travel accident (BTA) insurance.

When you elect employee-only 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.

When you elect employee + 1 or employee + 2 (or more) medical coverage, you will pay a percentage of the total premium cost based on your salary, and LMU will pay the remaining cost of 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.