

LLNS

Health and Welfare Benefit Plan for Retirees

Summary Plan Description

Effective October 1, 2017

IMPORTANT

This Summary Plan Description (SPD) is intended to provide a summary of the principal features of the LLNS Health and Welfare Benefit Plan for Retirees ("Plan"). Additional information about component Benefit Programs is found in the Benefit Program Materials referenced in [Appendix C](#). The documents referred to in Appendix C and any updates to those documents are hereby incorporated by reference into the SPD and the Plan.

This SPD will continue to be updated. Please check back on a regular basis for the most recent version.

Nothing in the Plan and/or this SPD shall be construed as giving any participant the right to be retained in service with LLNS or any affiliated company, or as a guarantee of any rights or benefits under the Plan. LLNS, in its sole discretion, reserves the right to amend or terminate in writing at any time the Plan, SPD and/or any Benefit Program. No benefit described in the Plan will be considered to "vest."

The Plan is governed by a Federal law (known as ERISA), which provides rights and protections to Plan participants and beneficiaries. Copies of the Plan document are on file with the Plan Administrator. You may obtain and/or read the Plan document at any reasonable time. You may also submit a written request to the Plan Administrator requesting a copy of the Plan document. The Plan document may provide additional details regarding the benefits and operation of the Plan.

For questions or to receive a paper copy of this SPD please contact the Empyrean Lawrence Livermore Customer Care Center at 844-750-5567. SPDs are also available electronically from Empyrean's Website at www.llnsretireebenefits.com or at <https://benefits.llnl.gov/retirees>.

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1. Introduction

General Information

This Summary Plan Description (“SPD”) describes the health and welfare Benefit Programs sponsored by Lawrence Livermore National Security, LLC (“LLNS”) and made available to eligible retirees of LLNS and their eligible dependents through the LLNS Health and Welfare Benefit Plan for Retirees (“Plan”). For purposes of this Plan, retiree means an individual who meets the eligibility requirements in [Section 2](#), below.

Please share this SPD with your family members.

LLNS maintains the Plan to provide benefits for the exclusive use of its eligible retirees and their eligible dependents and beneficiaries.

When the term “family member” or “dependent” is used in this SPD, it generally refers to spouses (as defined under federal law), domestic partners, and children, who are related to an eligible retiree or a legal ward to age 18. Please read [Section 2. Eligibility Requirements](#) very carefully, because each Benefit Program may define the term “dependent” in a slightly different way.

The Benefit Program Materials referenced in [Appendix C](#), together with any updates (including any Summary of Material Modifications (SMMs)) and open enrollment materials, are hereby incorporated by reference into this SPD and the Plan.

This document, including all documents incorporated by reference, is intended to meet the SPD requirements of the Employee Retirement Income Security Act of 1974 (“ERISA”).

Plan Details

For detailed information, please refer to:

- [Appendix A](#) for Premium Contribution Arrangement information;
- [Appendix B](#) for eligibility information for surviving family members;
- [Appendix C](#) for a list of the Benefit Program materials;

- [Appendix D](#) and [Section 8. Claim and Appeals Procedures](#) for claims and appeals administration information;
- [Appendix E](#) for funding and contract administration information;
- [Appendix F](#) for the Customer Care Center and COBRA Administrator; and
- [Appendix G](#) for Plan administration information.

LLNS Benefits

Some of the Benefit Programs that may be offered by LLNS from time to time as listed in [Appendix C](#) are:

- Medical (including prescription drug coverage),
- Dental,
- Legal, and
- Accidental death and dismemberment (AD&D).

Customer Care Center

For information about your benefits, please contact:

Empyrean – Customer Care Center

Telephone 844-750-5567

Website www.llnsretireebenefits.com

OneExchange – Medicare Eligible Benefit Advisor

Telephone 866-682-4841

Website <https://medicare.oneexchange.com>

Keep Your Records Updated

Make sure that Empyrean always has your current home address and telephone number to correctly administer your benefits.

Please notify the Empyrean Customer Care Center, listed in [Appendix F](#), to update your personal information, such as your home address and home telephone number.

2. Eligibility Requirements

This section describes the general eligibility rules and coverage terms under the Plan. These eligibility rules and coverage terms are subject to change. Please read this section carefully to learn about eligibility for retiree welfare benefits.

Eligibility for Retiree Welfare Benefits

To qualify for Plan benefits (medical, dental, legal, AD&D), you must meet the requirements in any one of the following categories and all other applicable requirements of the Plan:

- A. Be a former employee of the University of California (UC) at Lawrence Livermore National Laboratory (LLNL) (or current or surviving family member of such former UC-LLNL employee) who was receiving or was eligible to receive retiree welfare benefits from UC on September 30, 2007; or
- B. Be a former employee of UC at LLNL who terminated from UC before October 1, 2007, and who, within 120 days of termination from UC, elected to receive a monthly pension from the University of California Retirement Plan (UCRP); or
- C. Be a former employee of LLNS who is a UC Transitioning Employee¹ who properly elected TCP1, and who is vested with 5 years of Service Credits⁴ and is eligible to receive a monthly disability benefit under the LLNS Defined Benefit Eligible Disability Program and who applies for LLNS Health and Welfare benefits within 120 days of termination from LLNS; or
- D. Be a former LLNS employee who retires from a benefits-eligible appointment at LLNS on or after October 1, 2007, and who applies for LLNS Health and Welfare benefits within 120 days of termination from LLNS, *and who is*
 1. a UC Transitioning Employee¹ who properly elected TCP1 and is receiving a monthly pension from the LLNS Defined Benefit Pension Plan; or
 2. a UC Transitioning Employee¹ who properly elected TCP2 who is receiving a monthly pension from the UCRP; or
 3. a Direct Transfer Employee² hired on or after October 1, 2007; or

4. a LLNS employee hired on or after October 1, 2007.

- E. Be a former employee of LLNS who is a UC Transitioning Employee¹ who elected a lump sum payment through the UCRP and who retires from a benefits eligible appointment at LLNS on or after October 1, 2007, and who applies for LLNS Health and Welfare benefits within 120 days of termination from LLNS.

For purposes of **B.** and **D.**, above, to be eligible for retiree welfare benefits you must *also* either:

- be at least age 50 with at least 10 years of applicable Service Credits⁴; as of the date of retirement; or
- have at least 5 years of applicable Service Credits⁴ and meet the “Rule of 75” as of the date of retirement.³

For purposes of **E.** above, you must have at least 10 years of applicable Service Credits⁴

For purposes of **B.**, **C.** and **D.** and **E.** above, to be eligible for retiree medical, dental, or legal benefits, you must *also* have continuous coverage in the applicable benefit (which, with respect to medical and dental coverage, may include COBRA continuation coverage) in a LLNS-sponsored group medical, dental or legal Benefit Program from the date of termination to the date retiree benefits begin. You may apply for AD&D benefits by contacting the AD&D Benefit Program provider listed in [Appendix D](#).

¹ A UC Transitioning Employee means an employee of LLNS who joined LLNS on October 1, 2007, and was employed by the University of California (UC) on September 30, 2007.

² A Direct Transfer Employee means an employee of LLNS who transfers to LLNS directly from UC (excluding UC-LLNL), Bechtel, BWXT or The Washington Group (LLNS Parent Companies) or directly from an Affiliate of a LLNS Parent Company. An Affiliate of a LLNS Parent Company is any company partially or fully owned by a LLNS Parent Company.

³ The Rule of 75 means your age (in whole years) plus Service Credits equal 75.

⁴ Service Credits means years of service calculated by and transferred to LLNS from any LLNS Parent Company and/or, for service with LLNS on or after October 1, 2007, years of service calculated by LLNS generally based on the methodology used to calculate Credited Service under the LLNS Defined Benefit Pension Plan (whether or not the employee is eligible for the LLNS Defined Benefit Pension Plan).

Service Credits¹ for *Eligibility* for Retiree Health & Welfare Benefits

Category of Retiree	Service Credits for <i>Eligibility</i> for Retiree Welfare Benefits
A	Service Credits ¹ are based on years of service with UC.
B	Service Credits ¹ are based on years of service with UC.
C	Service Credits ¹ are based on years of service with UC frozen upon transfer to LLNS on October 1, 2007, <i>and</i> years of service at LLNS beginning October 1, 2007.
D.1	Service Credits ¹ are based on years of service with UC frozen upon transfer to LLNS on October 1, 2007, <i>and</i> years of service at LLNS beginning October 1, 2007.
D.2	Service Credits ¹ are based on years of service with UC frozen upon transfer to LLNS on October 1, 2007 for purposes of determining level of graduated eligibility <i>and</i> years of service at LLNS beginning October 1, 2007, for purposes of access only eligibility.
D.3	Service Credits ¹ are based on years of service with LLNS Parent Company and/or Affiliate frozen upon transfer to LLNS on date of hire at LLNS <i>and</i> years of service at LLNS beginning with date of hire at LLNS. Service Credits with LLNS Parent Company and/or Affiliate are based on years of work performed on Department of Energy (DOE) Management and Operating, Environmental Management and other DOE Prime Contracts with the LLNS Parent Company and/or Affiliate (including predecessor contractors).
D.4	Service Credits ¹ are based on years of service with LLNS.
E	Service Credits ¹ are based on years of service with UC frozen upon transfer to LLNS on October 1, 2007, <i>and</i> years of service at LLNS beginning October 1, 2007, for access only eligibility.

For information on Service Credits¹ for **LLNS Contributions** to retiree welfare benefits, please see [Appendix A](#).

¹ Service Credits means years of service calculated by and transferred to LLNS from any LLNS Parent Company and/or, for service with LLNS on or after October 1, 2007, years of service calculated by LLNS generally based on the methodology used to calculate Credited Service under the LLNS Defined Benefit Pension Plan (whether or not the employee is eligible for the LLNS Defined Benefit Pension Plan).

Eligible Family Members

Family members may be eligible for health and welfare benefits as:

- the eligible family members of a retiree receiving retiree welfare benefits under this Plan; or
- the eligible surviving family members of certain employees, certain former employees (not retired) and certain retirees as set forth in [Appendix B](#).

Throughout this SPD, the term “spouse” or “legal spouse” means spouse as defined by applicable federal law unless otherwise provided under the terms of a fully-insured Benefit Program.

Coverages for Family Members

Family members are eligible for medical, dental and legal coverage as long as they meet the requirements outlined in this section.

AD&D coverage is available only to you and your spouse or domestic partner.

Your eligible family member(s) other than surviving family members are eligible only for the Benefit Program(s) in which you have enrolled (except if you are enrolled in a Medicare plan). For non-Medicare medical benefits and dental benefits, family members must be covered under the same Benefit Program as you.

Eligible Adults

The following are eligible adults under the Plan unless otherwise provided under the terms of a fully-insured Benefit Program:

- your legal spouse as defined under applicable federal law; or
- your domestic partner who meets the requirements in the LLNS Declaration of Domestic Partnership; or
- If opposite sex spouse or domestic partner, the retiree/employee must be age 62 or older and eligible to receive Social Security benefits based on age; or
- your adult dependent relative who was eligible for UC welfare benefits as of December 31, 2003, and who, as of September 30, 2007, is on a list of Adult Dependent Relatives provided to LLNS by UC.

In addition to yourself, you may have only *one* eligible adult family member enrolled in your LLNS-sponsored retiree Benefit Programs.

For example, if you cover an adult dependent relative on your medical and dental Benefit Programs, you may also not enroll your spouse in **any** LLNS-sponsored Benefit Program.

Eligible Children

Children who meet the criteria below are eligible for medical, dental, and legal benefits.

Note that your disabled child aged 26 or older is still considered to be your eligible child and not an adult dependent. You may enroll your domestic partner's child or legal ward even if you do not enroll your domestic partner; however, your domestic partner must meet the requirements in the LLNS Declaration of Domestic Partnership.

Child	Eligibility	Must meet all applicable requirements
Natural, stepchild, placed for adoption or adopted child or foster child	To age 26	<ul style="list-style-type: none"> ▪ no additional requirements
Domestic partner's child: Domestic partner must meet the requirements in the LLNS Declaration of Domestic Partnership available from the LLNL Benefits Office .	To age 26	<ul style="list-style-type: none"> ▪ unmarried ▪ living with you ▪ supported by you or your domestic partner (50%+) ▪ claimed as a tax dependent by you or your domestic partner
Legal ward	To age 18	<ul style="list-style-type: none"> ▪ unmarried ▪ living with you ▪ supported by you (50%+) ▪ claimed as your tax dependent
Overage disabled child (except a legal ward) of retiree	Age 26 or older	<ul style="list-style-type: none"> ▪ unmarried ▪ living with you if not your natural or adopted child ▪ enrolled in a UC or LLNS group medical benefit program before age 26 with continuous coverage and the incapacity must have begun before age 26 ▪ once eligible, continuous coverage under a LLNS group medical benefit program must be maintained for the overage dependent; if coverage is dropped, coverage is no longer available ▪ supported by you (50%+) and claimed as your dependent for income tax purposes or eligible for Social Security income or Supplemental Security Income as a disabled person. The overage disabled child may be working in supported employment which may offset the Social Security or Supplemental Security Income ▪ incapable of self-support due to a mental or physical disability incurred prior to age 26, as determined by the medical carrier ▪ must be approved as disabled before age 26

Ineligible Family Members

Certain family members are not eligible to participate in LLNS-sponsored Benefit Programs, unless they qualify as your adult dependent relative or eligible child. Ineligible family members include, but are not limited to:

- siblings,
- in-laws,
- cousins,
- former spouses,
- former stepchildren,
- former domestic partners, and
- your children's spouses/domestic partners

Qualified Medical Child Support Orders (QMCSOs)

A QMCSO is any judgment, decree or order, including a court-approved settlement agreement, that:

- is issued by
 - a domestic relations court or other court of competent jurisdiction, or
 - through an administrative process established under state law which has the force and effect of law in that state,
- assigns to a child the right to receive health benefits for which the child of a participant is eligible under the Plan, and
- the Plan Administrator determines is qualified under the terms of ERISA and applicable state law.

You can get a copy of the Plan's QMCSO procedures upon request to the Plan Administrator listed in [Appendix G](#) at no cost to you.

In general, only children who meet the eligibility requirements as dependents – for example, by meeting the age requirements – can be covered under a QMCSO.

No Duplicate Coverage

Plan rules do not allow duplicate coverage.

This means you may not be covered in any LLNS-sponsored program as a retiree and as an employee or as an eligible family member of a LLNS employee or retiree at the same time.

If you are covered as a family member and then become eligible for LLNS coverage yourself, you have two options:

- You can either waive the coverage and remain covered as another employee or retiree's dependent **or**
- You can make sure the LLNS employee or retiree who has been covering you de-enrolls you from his or her LLNS-sponsored program before you enroll yourself.

Family members of LLNS retirees and employees may not be covered by more than one LLNS retiree's or employee's program coverage. For example, if a husband and wife are both LLNS retirees, their children cannot be covered by both retirees as family members for medical coverage or any other coverage.

If duplicate enrollment occurs, LLNS will cancel the later enrollment. The Plan reserves the right to collect reimbursement for any duplicate premium payments and for any Plan benefits provided due to the duplicate enrollment.

For additional information, refer to the applicable Benefit Program material listed in [Appendix C](#).

Misuse of Plan

LLNS reserves the right to de-enroll individuals and their family members who misuse the Plan. Misuse of the Plan includes, but is not limited to, actions such as falsifying enrollment or claims information, allowing ineligible individuals to use Plan identification cards, and threats or abusive behavior towards Plan providers or representatives.

Insurance carriers may have their own rules that apply to misuse of the insured Benefit Program in which you are enrolled. See the applicable Benefit Program material listed in [Appendix C](#) for details regarding the insurers' rules, which will govern if they conflict with the Plan rules.

Documentation

To verify eligibility for your family members, LLNS and the insurance carriers and third party administrators may request documentation needed to verify the relationship, including but not limited to birth certificates, adoption records, marriage certificates, verification of domestic partnership, and tax documentation. See [Section 11. General Plan Provisions, Administration of Plan](#).

In addition, LLNS may request information from you regarding Medicare eligibility and enrollment, family member eligibility, address information, and more. You are required to promptly provide the requested information.

LLNS reserves the right to de-enroll individuals and their family members for failing to provide documentation when requested. In addition, retirees will be responsible for employer contributions to and benefits paid by the Plan for coverage provided to ineligible individuals.

Loss of Family Member Eligibility

Whenever a family member loses eligibility to participate in LLNS-sponsored Benefit Programs, it is your responsibility to de-enroll that family member from the Benefit Program within 31 calendar days by contacting the Customer Care Center in [Appendix F](#). If you do not, you are liable for any excess LLNS costs and for any Benefit Program expenses incurred by the ineligible family member. Premiums will not be refunded retroactively if the retiree does not cancel or delete a family member within 31 days of the loss of eligibility. See "Ineligible Persons" in this section for more details.

See [Section 9. Continuation of Health Care Coverage](#), for information about COBRA.

Rehired Retirees with Medicare

If you return to work for LLNS after retirement and are hired into a position eligible for medical benefits, your coverage as a retiree will be affected. For further information and assistance please contact the [LLNL Benefits Office](#).

Certain people with disabilities who are under age 65, and people of any age who have permanent kidney failure can become eligible

for Medicare coverage 24 months after their Social Security Disability Income ("SSDI") benefits begin.

Mandated Medicare – Your Responsibility

Medicare is the federal health insurance program administered by the Centers for Medicare and Medicaid Services (CMS).

Medicare includes: Medicare Part A (hospital insurance), Medicare Part B (medical insurance), and Medicare Part D (prescription drug coverage).

People age 65 or older, certain people with disabilities who are under age 65, and people of any age who have permanent kidney failure can become eligible for Medicare coverage. Medicare coverage for disabled individuals may commence 24 months after their Social Security Disability Income ("SSDI") benefits begin.

Medicare Part A and Part B: LLNS requires each retiree, disabled member, and enrolled family member who is eligible to enroll in Medicare Part A and Part B *when first eligible for Medicare*. * If enrolled in Part B, you cannot cancel enrollment at some future date and remain covered under the Plan. Those who do not comply with this requirement will be terminated from coverage under the LLNS medical benefit program and will not be eligible for certain benefits.

*Retirees who were retired from the University of California-LLNL and age 65 as of June 30, 1991, are not subject to the requirement to be enrolled in Medicare Part A and B. Members of the Medicare Offset Group who are not enrolled in Medicare Part B must pay an additional amount which is subject to change from year to year.

3. How to Enroll

Retirees

At the time you become eligible for retiree benefits, you will receive information about how to enroll in retiree medical, dental, Legal and/or AD&D benefits.

It is your responsibility to enroll in retiree benefits for which you are eligible within 31 days of your date of eligibility. Eligibility begins the first of the month following the date of termination from LLNS, or the date of retirement if within 120 days of your termination from LLNS, whichever is later.

However, keep in mind that you must maintain payment of your required premiums during the 120 day period or you will not be eligible to elect the benefits.

If you do not wish to enroll in the Legal or AD&D Benefit Programs, you do not have to take any action and you will not be enrolled.

If you do not receive the initial enrollment information from LLNS, please contact the Customer Care Center in [Appendix F](#).

Period of Initial Eligibility (PIE)

A PIE is a time during which you and/or, as applicable, your eligible family members may enroll in LLNS-sponsored retiree Benefit Programs.

A PIE starts on the first day of eligibility and ends 31 days later—for example, a PIE starts on the day you become eligible for retiree benefits or the day you marry.

Other Periods of Initial Eligibility

New Family Member. A newly eligible family member's PIE starts the day he or she becomes eligible (for example, the day you marry or your child is born). A non-immigrant alien child becomes eligible to enroll on the date the child enters the United States. Enrollment is not automatic; you must enroll the new family member within 31 days of the event. Coverage begins on the first day of the PIE in which you enroll the family member.

Adopted Child. The PIE for an adopted child begins on the earlier of the date the child is placed in your physical custody or the date you, your spouse, or domestic partner has the legal right to control the child's health care. If you do not enroll

your child during this PIE, a second PIE begins on the date the adoption is final. Coverage begins on the first day of the PIE in which you enroll the child.

Suspending Medical or Dental Coverage

After you retire you may "suspend" the medical or dental coverage. You are not permitted to *suspend* the legal benefit coverage.

When medical or dental coverage is suspended, it also suspends LLNS-sponsored medical or dental coverage for all enrolled eligible family members, and LLNS employer medical benefit program contributions.

If a retiree or survivor is enrolled in a LLNS-sponsored legal benefit program, that coverage will continue for the retiree or survivor and eligible family members.

To suspend LLNS-sponsored medical or dental coverage, a retiree or survivor must contact the Emyrean Customer Care Center at 1-844-750-5567.

Once medical or dental coverage is suspended, the retiree has the following opportunities to re-enroll in a LLNS-sponsored medical or dental benefit program:

- **Open Enrollment.** You may re-enroll in a LLNS-sponsored medical or dental benefit program during any future open enrollment period (usually held in the fall), whether or not you are covered by other medical or dental coverage, unless the other coverage is non-LLNS Medicare Part D coverage. LLNS-sponsored medical coverage is effective January 1 of the following year. See Section 2. Eligibility Requirements, Mandated Medicare – Your Responsibility for information regarding enrolling in medical coverage.
- **Involuntary Loss of Other Coverage (ILOC).** You may re-enroll in a LLNS-sponsored medical or dental benefit program as described in [Section 7. Making Changes to Your Medical, Dental, or Legal Benefit Program Elections](#). You will have a new PIE in which to enroll in a LLNS-sponsored medical or dental benefit program. Your LLNS enrollment must be submitted within 31 days of the ILOC. Coverage begins on the first day of the PIE in which you enroll.

Annual Open Enrollment

If you are a current retiree, you may generally enroll for coverage, change your coverage level, or waive coverage during the annual open enrollment period which is usually held in the fall. Open enrollment elections are effective at the beginning of the Plan Year (generally January 1 of the following year). If you do not change your elections during open enrollment, your coverage levels will continue from the previous year with the exception of possible rate changes.

When Coverage Begins

The date coverage begins will depend on when you are enrolled for coverage under a Benefit Program, and the terms of the Benefit Program in which you are enrolled. In general, coverage under the Plan begins the first of the month following the date of termination from LLNS, or the date of retirement if within 120 days of your termination from LLNS, whichever is later. For more information, review the applicable Benefit Program material listed in [Appendix C](#).

When Coverage Ends

Retirees

Retiree coverage generally ends:

- the last day of the month in which you fail to make a required contribution,
- the last day of the month in which you become ineligible for coverage, or
- the date the Plan or Benefit Program terminates,

and/or as further described in the Benefit Program material, whichever occurs first.

Dependents of Retirees

Coverage for dependents generally ends:

- the last day of the month in which you fail to make a required contribution,
- the last day of the month in which your dependent ceases to be eligible for coverage,
- the day retiree coverage ends unless dependent coverage specifically continues regardless of retiree's enrollment, or
- the date the Plan or Benefit Program terminates,

and/or as further described in the Benefit Program material, whichever occurs first.

HIPAA Certificate of Creditable Coverage

When your medical coverage ends, you may receive a certificate of creditable coverage that:

- confirms that you had medical coverage under the Plan; and
- states how long you were covered.

If you become eligible for other medical coverage that excludes or delays coverage for certain pre-existing conditions, you can use this certificate to receive credit – against the new program's pre-existing condition limit – for the time you were covered by the Plan. The certificate may also be useful in helping you obtain group or individual health insurance coverage.

You may request an additional certificate from your medical Benefit Program listed in [Appendix D](#) at any time while covered and within 24 months after coverage ends.

4. Paying for Coverage

You and LLNS share the cost of coverage under certain Benefit Programs, as described in [Appendix A](#). LLNS will inform you before you enroll of your share of the cost of coverage for the relevant time period. During that time period, you will pay that fixed portion of the cost and LLNS pays the balance of the cost. Your portion of the cost varies according to your eligibility status, benefits and coverage levels (i.e., single, family, etc.). For more information, refer to [Appendix A](#).

The cost of coverage does not include your costs for any applicable deductibles, co-payments, out-of-network charges, or non-covered items. For more information, please see the Benefit Program material listed in [Appendix C](#) for the benefits in which you are enrolled.

Changes to Coverage and Contributions

Premiums are paid in advance by direct payment to the Customer Care Center (see [Appendix F](#)) for medical and dental coverage, and by direct payment to the legal and AD&D Benefit Programs listed in [Appendix D](#).

If a change is made to retiree coverage for medical or dental as a result of a retiree's PIE before the 15th day of the month the retiree will be responsible for paying the new rate for coverage in that month. If the change is effective on or after the 15th of the month, the retiree will begin paying the new rate for coverage in the following month.

Refer to your legal and AD&D Benefit Programs for information about rate changes.

Retiree Contributions for Benefits

All retiree contributions for benefits are paid on an after-tax basis.

LLNS Contributions for Benefits

LLNS contributions for benefits are generally not taxable income to retirees.

Imputed income. However, LLNS contributions for coverage for individuals who do not meet the criteria for tax-favored health benefits under the IRC will result in imputed income to you. The box to the right summarizes the federal rules for tax-favored benefits. For example, to receive tax-favored health

benefits, your dependent children must qualify in either the category of "Qualifying Children" or "Qualifying Relative" and your domestic partner must qualify in the category of "Qualifying Relative." Special rules apply for divorced parents.

Please contact the [Customer Care Center](#) if you have questions concerning domestic partner, dependent child or other eligibility.

Federal Tax Rules For Tax-Favored Health Benefits

Individuals who are otherwise eligible for medical and dental Benefit Program coverage under this Plan generally must also satisfy the following criteria in order to receive tax-favored health benefits within the meaning of the Internal Revenue Code (IRC):

- "Qualifying Children". Qualifying Children are your children by birth, adoption, stepchildren, or foster children who:
 - are under age 19, or under age 27 in the case of a full-time student, on the last day of the calendar year; and
 - do not provide over one-half of their own support; and
 - have the same principal place of residence as you for more than six months of the year (temporary absences, such as for school, are treated as time at the same principal place of residence).
- "Qualifying Relatives". Qualifying Relatives include:
 - Your children (by birth, adoption, stepchildren or foster children) of any age who receive over half of their support from you and who do not meet the above "qualifying child" requirements with respect to any other person; or
 - Individuals who share your residence as a member of your household, who receive over half of their support from you, and who do not meet the above "qualifying child" requirements with respect to any other person.

Please also see IRS Publication 502 for a discussion of the definition of a tax dependent. The publication is available at www.irs.ustreas.gov/prod/forms_pubs.

5. Health Program Information

The Plan includes health (e.g., medical and dental) programs.

Benefit Program Material

The Benefit Program material for the health program in which you are enrolled is available on www.llnsretireebenefits.com. If you wish to receive a hardcopy of this material, you may contact your health Benefit Program listed in [Appendix D](#) or the Empyrean Customer Care Center at 1-844-750-5567.

The Benefit Program material listed in [Appendix C](#) describes the nature of covered services including, but not limited to:

- coverage of drugs, emergency care, preventive care, medical tests and procedures, hospitalization and durable medical equipment;
- eligibility to receive services;
- exclusions, limitations, and terms for obtaining coverage (such as rules regarding preauthorization and utilization review);
- cost sharing (including deductibles and co-payment amounts);
- annual maximums and other caps or limits;
- circumstances under which services may be denied, reduced, or forfeited;
- procedures, including pre-authorization and utilization review, to be followed in obtaining services; and
- procedures available for the review of denied claims.

You may also obtain a copy of the Benefit Program material for the health program in which you are enrolled by contacting the program directly at the address or phone number listed in [Appendix D](#). Or, you may contact the Customer Care Center at the numbers listed in [Appendix F](#).

Provider Networks

If you are enrolled in a health program that offers benefits through provider networks, a list of providers is available on the provider's website listed in Appendix D. You may also contact the health program at the address, phone number, or website listed in [Appendix D](#).

Refer to the Benefit Program material in [Appendix C](#) for your health program for a description of:

- how to use network providers,
- the composition of the network,
- the circumstances under which coverage will be provided for out-of-network services, and
- any conditions or limits on the selection of primary care providers or specialty medical providers that may apply.

Generally, if you participate in a health program that provides benefits through a network of providers, benefits will be paid only if your provider participates in or is associated with a network that your health program uses. In addition, some health programs may require a referral from a primary care physician before a patient can be treated by a specialty provider.

Maternity Hospital Stays (Newborns' and Mothers' Health Protection Act)

Federal law protects the benefit rights of mothers and newborns related to hospital stays in connection with childbirth. In general, group health programs and health insurance issuers may not:

- restrict benefits for the length of hospital stay for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does allow the mother's or newborn's attending provider, after consulting with the mother, to discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable).
- require that a provider obtain authorization from the plan or the insurance issuer for

prescribing a length of stay of up to 48 hours (or 96 hours).

For details on any state maternity laws that may apply to your medical program, please refer to the Benefit Program material in [Appendix C](#) for the medical program in which you are enrolled.

Benefits for Mastectomy-Related Services (Women's Health and Cancer Rights Act)

The medical programs sponsored by LLNS will not restrict benefits if you or your dependent:

- receives benefits for a mastectomy, and
- elects breast reconstruction in connection with the mastectomy.

Benefits will not be restricted provided that the breast reconstruction is performed in a manner determined in consultation with your or your dependent's physician and shall include:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Benefits for breast reconstruction will be subject to annual deductibles and coinsurance amounts consistent with benefits for other covered services under the program.

For details on any state laws that may apply to your medical program and any mastectomy-related coverage it provides, please refer to the Benefit Program material in [Appendix C](#) for the medical program in which you are enrolled.

No Pre-existing Conditions Limitations

When you enroll in any LLNS-sponsored medical or dental program, you will not be excluded from enrollment based on your health, nor will your premium or level of benefits be based on any pre-existing health conditions. The same applies to your dependents.

6. Other Benefits Information

Benefit Program Material

This section discusses Benefit Programs other than health benefits. For health benefit information, see [Section 5. Health Program Information](#).

Benefit Program materials for the program in which you are enrolled generally will be sent to you. If you don't receive this material, contact the Benefit Program listed in [Appendix D](#).

The Benefit Program material listed in [Appendix C](#) describes the nature of covered services including, but not limited to:

- eligibility to receive services;
- exclusions, limitations, and terms for obtaining coverage, including any requirements to provide evidence of good health or insurability;
- cost sharing;
- annual maximums and other caps or limits;
- circumstances under which services may be denied, reduced, or forfeited;
- procedures to be followed in obtaining services
- procedures available for the review of denied claims.

You may also obtain a copy of the Benefit Program material for the program in which you are enrolled by contacting the program directly at the address or phone number listed in [Appendix D](#).

Accident Benefits

Retirees of LLNS are eligible for retiree-paid accidental death and dismemberment (AD&D), benefits if they meet the requirements described in [Section 2. Eligibility Requirements](#) and in the applicable Benefit Program material listed in [Appendix C](#). If you have questions about the Benefit Program, please contact your Benefit Program directly, as listed in [Appendix D](#).

Eligible retirees may elect to cover their spouses or domestic partners. In addition to eligibility, the Benefit Program material may describe the coverage, terms, limitations, and costs to you.

Legal Benefit Program

The LLNS former employee-paid group legal benefit program provides basic legal services for eligible former employees and their eligible family members. You may enroll within 31 days of retirement or during Open Enrollment (if the Legal Plan is open for new enrollments). To enroll, contact Empyrean Customer Care Center at 844-750-5567 or log on to www.llnsretireebenefits.com.

7. Making Changes to Your Medical, Dental, or Legal Benefit Program Elections

In general, the Benefit Programs and coverage levels you choose when newly eligible and at open enrollment remain in effect through the end of the plan year. See [Section 3. How to Enroll, Annual Open Enrollment](#), for more information on your elections at open enrollment.

However, you may be able to change your elections between annual open enrollment periods if certain events occur, as further explained below. Any changes will be administered by the Plan in accordance with the Internal Revenue Code and applicable regulations. Any changes will be administered by the Plan in accordance with applicable law.

You must contact the Empyrean Customer Care Center in [Appendix F](#) within 31 days of the event to request this change. Otherwise, your next opportunity to enroll new dependents or make other Benefit Program changes is generally the next annual open enrollment period or the date you experience a special enrollment event as described below, whichever occurs first.

Life Events

The following is a list of Life Events that allow you to make a change to your elections mid-year as long as the consistency requirements are met. (See Consistency Requirements, described below):

- **Legal marital status.** An event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, or annulment.
- **Domestic partnership status.** An event that changes the status of your domestic partnership, including establishment or termination of a domestic partnership or death of your domestic partner.
- **Number of dependents.** An event that changes your number of dependents, including birth, death, adoption, and placement for adoption.

- **Employment status.** An event that changes your spouse's or your other dependent's employment status that results in gaining or losing eligibility for coverage. Examples include:
 - Beginning or terminating employment,
 - Changing from part-time to full-time employment or vice versa, or
 - A change in worksite
- **Dependent status.** An event that causes your dependent to become eligible or ineligible for coverage because of age or other circumstance.
- **Residence.** A change in the place of residence of you, your spouse or another dependent.

Consistency Requirements

The change you make to your benefit elections must be "due to and consistent with" your Life Event. To satisfy the federally required "consistency rule," your Life Event and corresponding change in coverage must meet both of the following requirements.

- **Effect on eligibility.** The Life Event must affect eligibility for coverage under the Plan or under a plan sponsored by the employer of your spouse or other dependent. For this purpose, eligibility for coverage is affected if you become eligible (or ineligible) for coverage or if the Life Event results in an increase or decrease in the number of your dependents who may benefit from coverage under the Plan.
- **Corresponding election change.** The election change must correspond with the Life Event. For example, if your dependent loses eligibility for coverage under the terms of a health program due to age, you may cancel health coverage only for that dependent.

You must contact the Empyrean Customer Care Center within 31 days of the event. Otherwise, your next opportunity to make changes will be the next open enrollment period or when you have another Life Event (or other applicable event) whichever occurs first.

Coverage and Cost Events

In some instances, you can make mid-year changes to your benefits coverage for other reasons, such as mid-year events affecting your cost or coverage, as described below.

Coverage Events

If LLNS adds, eliminates or significantly reduces a Benefit Program in the middle of the Plan year, or if LLNS-sponsored coverage is significantly limited or ends, you and your dependents can elect different coverage in accordance with IRS regulations.

Here are some examples:

- If there is an overall reduction under a Benefit Program so as to reduce coverage to participants in general, participants enrolled in that Benefit Program may revoke their election and elect coverage under another option providing similar coverage.
- If LLNS adds another Benefit Program mid-year, participants can drop their existing coverage and enroll in the new program. You and/or your eligible dependents may also enroll in the new Benefit Program even if not previously enrolled for coverage at all.
- If another employer's plan allows you, your spouse, or your dependent child to make an election change during that plan's annual open enrollment period, you may make a corresponding mid-year election change, provided the other plan's plan year is a 12-month period other than the calendar year.
- If another employer's plan (for example, your spouse's employer) allows you, your spouse or your dependent child to change his or her elections in accordance with IRS regulations, you may make a corresponding mid-year election change to your coverage.

Cost Events

If your cost for health program coverage increases or decreases significantly during the Plan year, you may make a corresponding election change. For example, you may elect another Benefit Program with similar coverage, or drop coverage if no similar coverage is available.

In addition, if there is a significant decrease in the cost of a Benefit Program during the Plan year, you may enroll in that Benefit Program, even if you declined to enroll in that Benefit Program earlier.

Changes in the cost of your Benefit Program that are *not* significant will result in an automatic increase or decrease, as applicable, in your share of the total cost. If you are Medicare eligible, please check with your plan.

Involuntary Loss of Other Coverage (ILOC)

If you suspend enrollment for medical and dental coverage for yourself or your dependents (including your spouse, domestic partner or child) *because of other group coverage*, you may in the future be able to enroll yourself and your dependents in such coverage under the LLNS Plan, if you or your dependents experience an Involuntary Loss of Other Coverage (ILOC).

This rule applies if you meet both of the following conditions:

- You (or your dependents) were covered under other coverage (for example, under another employer's medical plan) when LLNS coverage was previously offered to you; and
- You (or your dependents) lose other coverage because:
 - You or your dependent exhaust rights to COBRA coverage, or
 - The employer's contributions to the other coverage stop, or
 - You or your family member is no longer eligible under that plan. A "loss of eligibility" for coverage does not include a loss due to a failure to timely pay premiums or termination of coverage for cause.

If you or your dependent lose other group health coverage due to an ILOC as described above, you may enroll yourself and your eligible dependents in a LLNS medical or dental program within 31 days of the loss of coverage.

Acquiring new dependents. If you are enrolled in a LLNS health program, when you acquire a newly eligible dependent spouse, domestic

partner or child (through marriage, domestic partnership, birth, adoption, or placement for adoption), you may enroll your spouse, domestic partner and/or eligible dependent children in the same LLNS health program within 31 days of the date you acquire the new dependent.

Coverage will start on the date of birth or placement for adoption as long as the child is enrolled within 31 days of the date of birth or placement for adoption.

Other Rules on Changing Coverage

Medicare Entitlement. You are required to change an election for medical coverage mid-year if you, your spouse, or dependent becomes entitled to Medicare or Medicaid coverage. However, you're limited to reducing your coverage only for the person who becomes entitled to Medicare or Medicaid, and you're limited to adding coverage only for the person who loses eligibility for Medicare or Medicaid.

Judgment, Decree, or Order. You may revoke an election for health coverage mid-year and make a new election if a judgment, decree, or order requires health coverage for your eligible child. The order must have resulted from a law relating to medical child support as described in 42 U.S.C. Section 1396g-1 or a divorce, legal separation, annulment, change in legal custody or other provision of state domestic relations law, and must meet the requirements of a qualified medical child support order (QMCSO).

You may change your health program election to provide coverage for the eligible child if the order requires coverage under your health program. You may also cancel coverage for the child if the order requires your spouse, former spouse, or other individual to provide coverage for the child, but only if coverage for the child is actually provided. Proof of that other coverage may be required.

Special Note Regarding Domestic Partner Coverage

The events qualifying you to make a mid-year election change described in this section also apply to events related to a dependent who is

your domestic partner or your domestic partner's tax dependent.

More Enrollment Information

Detailed information about enrollment and PIEs may be obtained from the Customer Care Center in [Appendix F](#).

8. Claims and Appeals Procedures

Important Note

The claims procedures outlined below are representative of the actual claims procedures followed by the Claims Administrators of Benefit Programs that are subject to ERISA and offered under the Plan. See the applicable Benefit Program material in [Appendix C](#) for the claims procedure that the Claims Administrator will follow.

Any claim or appeal for a specific benefit shall be timely made as specified in the applicable Benefit Program Summary directly to the Claims Administrator for that specific benefit.

In the event [Appendix C](#) identifies the Plan Administrator as the Claims Administrator, the Claims Procedures set forth in this Section 8 apply.

A claim for benefits must be filed within twelve (12) months of the date the claim was incurred or as provided in the applicable insurance policy or administrative agreement. No action at law or in equity in any court or agency shall be brought to recover benefits under the Plan prior to the exhaustion of the applicable ERISA Claim and Appeal Procedures nor shall an action be brought at all unless it is brought within twelve (12) months after the date the Claims Administrator renders its final decision upon appeal or as provided in the applicable insurance policy or administrative agreement.

The claims procedures for each specific Benefit Program will be furnished automatically to you without charge. If you do not receive the claims procedures please contact the Customer Care Center in [Appendix F](#). If you do not receive the claims procedures for group legal or AD&D benefits, please contact the applicable Claims Administrator directly. See [Appendix D](#) for a list of Claims Administrators.

Health Benefit Claims and Appeals Procedures

Filing an Initial Claim

You (or your beneficiaries) must follow the claims procedures established by the health Benefit Programs (medical and dental). If you are required to file an initial claim for benefits, you must do so within the time specified by the Benefit Program and in accordance with the Benefit Program's established claim procedures. See the applicable Benefit Program material listed in [Appendix C](#) for details on filing claims. See [Appendix D](#) for a list of Claim Administrators and their contact information.

Appeals Procedures

The claims procedure outlined below applies to the self-funded health Benefit Programs offered under the Plan. Similar, but not identical claims procedures apply to other ERISA health benefits. See [Appendix E](#) for information on which Benefit Programs are self-funded and which are insured.

Health claims are divided into four categories: Urgent Care Claims, Pre-Service Claims, Post-Service Claims, and Concurrent Care Decisions. Different rules and timeframes apply to each type of claim, as described below.

Definitions

- **Claim.** Any request for program benefits made to the proper person in accordance with the program's claims filing procedures, including any request for a service that must be pre-approved. Claims must be submitted in writing to the appropriate Claims Administrator listed in [Appendix D](#).
- **Urgent Care Claim.** Any claim for health care or treatment that has to be decided more quickly because the normal timeframes for decision-making could seriously jeopardize your life or health or your ability to regain maximum function, or in the opinion of a physician with knowledge of your condition, subject you to severe pain that can't be adequately managed without the care or treatment addressed in the claim.

- **Pre-Service Claim.** Any claim for a health benefit – other than an Urgent Care Claim – that must be approved in advance of receiving medical care (for example, requests to pre-certify a hospital stay or for pre-approval under a utilization review program).
- **Post-Service Claim.** Any other type of health claim.
- **Concurrent Care Decision.** Any decision in which the program – after having previously approved an ongoing course of medical treatment provided over a period of time or a specific number of treatments – subsequently reduces or terminates coverage for the treatments (other than by program amendment or termination).
- **Adverse Decision or Adverse Decision on Appeal.** A denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a benefit. An adverse decision includes a decision to deny benefits based on: (i) an individual's being ineligible to participate in the program; (ii) utilization review; (iii) a service being characterized as experimental or investigational or not medically necessary or appropriate; and (iv) a concurrent care decision.
- **Authorized Representative.** An individual authorized to act on your behalf in pursuing a claim or appeal in accordance with procedures established by the program. For Urgent Care Claims, a health care professional with knowledge of your medical condition may act as your authorized representative. (A health care professional is a physician or other health care professional who is licensed, accredited, or certified to perform specified health services consistent with state law.) For information about appointing an authorized representative, contact the Claims Administrator listed in [Appendix D](#).

Insufficient Claims

Improperly Filed Pre-Service Claim. If a Pre-Service Claim is not filed in accordance with the program's claim procedures, you will be notified as soon as possible, but no later than five days after it is received by the program. If the claim is

an urgent care case, you will be notified within 24 hours. Notice of an improperly filed Pre-Service Claim may be provided orally – or in writing, if you request. The notice will identify the proper procedures to be followed in filing the claim.

In order to receive notice of an improperly filed Pre-Service Claim, you or your authorized representative must have communicated your request regarding the claim to the Claims Administrator listed in [Appendix D](#). The request *must* include:

- the identity of the claimant;
- a specific medical condition or symptom; and
- a request for approval for a specific treatment, service or product.

Incomplete Urgent Care Claims. If a properly filed Urgent Care Claim is missing information needed for a coverage decision, you will be notified by the program as soon as possible, but no later than 24 hours after the claim has been received by the Claims Administrator. You will be notified of the specific information necessary to complete the claim.

You will have a reasonable amount of time considering the circumstances (but not less than 48 hours) to provide the specific information. The Claims Administrator will then provide notice of the claim decision as soon as possible, but no later than 48 hours after the earlier of:

- the date the Claims Administrator receives the specified information; or
- the end of the additional time period given for providing the information.

Notice of Benefit Determination

After your claim is reviewed by the Claims Administrator, you will receive a notice of benefit determination within the timeframes specified below. For Urgent Care and Pre-Service Claims, you will receive a notice of benefit determination whether or not the Claims Administrator makes an adverse decision on your claim. For Post-Service and Concurrent Care Claims, you are entitled to receive a notice of benefit determination if the Claims Administrator makes an adverse decision on your claim.

The timeframes for providing notice of a benefit determination generally start when a written claim for benefits is received by the Claims Administrator. Notice of a benefit determination may be provided in writing by hand delivery, mail, or electronic delivery. However, in some urgent cases, you may first be provided notice orally, which will be followed by written or electronic notice within three calendar (not business) days. The timeframes for providing a notice of benefit determination are as follows:

- **Urgent Care Claims.** As soon as possible considering the medical urgency, but not later than 72 hours after the Claims Administrator receives your claim.
- **Pre-Service Claims.** Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Claims Administrator receives your claim. This timeframe may be extended for up to 15 days for matters beyond the Claims Administrator's control.
- **Post-Service Claims.** In the case of an adverse decision, within a reasonable period of time, but not later than 30 days after the Claims Administrator receives your claim. This timeframe may be extended for up to 15 days for matters beyond the Claims Administrator's control.
- **Concurrent Care Decisions.** If an ongoing course of treatment will be reduced or terminated, you'll be notified at a time sufficiently in advance of the reduction or termination to allow you an opportunity to appeal.

If you request an extension of ongoing treatment in an urgent circumstance, you will be notified as soon as possible given the medical urgency, no later than 24 hours after the Claims Administrator receives your claim – provided the claim is submitted to the Claims Administrator at least 24 hours before the expiration of the prescribed time period or number of treatments.

If you request an extension of on-going treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to Post-Service or Pre-Service timeframes, whichever applies.

For Pre-Service and Post-Service Claims, the Claims Administrator may extend the timeframe for making a decision on your claim in certain cases. If an extension is necessary, you will be notified before the end of the initial timeframe (15 days for pre-service claims; 30 days for post-service claims) of the reasons for the delay and when the Claims Administrator expects to make a decision. Further, if an extension is necessary because certain information was not submitted with the claim, the notice will describe the required information that is missing, and you will be given an additional period of at least 45 days after you receive the notice to furnish the information. The Claims Administrator's extension period will begin when the notification of extension is sent and end when you respond to the request for additional information. The Claims Administrator will then notify you of the benefit determination within 15 days after your response is received.

Appeal of Adverse Decision

If you disagree with the decision on your claim, you (or your authorized representative) may file a written appeal with the applicable Claims Administrator within 180 days after your receipt of the notice of adverse decision. For a list of Claims Administrators, see [Appendix D](#). If you don't appeal on time, you may lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a requirement before you can sue in court).

You should include the reasons you believe the claim was improperly denied, and all additional facts and documentation you consider relevant in support of your appeal. The decision on your appeal will consider all comments, documentation, and records and other information you submit, even if they were not submitted or considered during the initial claim decision.

A new decision-maker will review your denied claim. The appeal will not be conducted by the individual who denied the initial claim or that person's subordinate. The new decision-maker will not give deference to the original decision on your claim. That is, the reviewer will give the

claim a “fresh look” and make an independent decision about the claim.

If your claim was denied based on medical judgment, the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in your claim. The health care professional will not be the same person (or a subordinate of the person) who was consulted on the initial decision. (A medical judgment includes whether a treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate.) The Claims Administrator will provide for the identification of medical or other experts whose advice was obtained in considering the original decision on your claim, whether or not the Claims Administrator relied on their advice.

For appeals of adverse benefits decisions involving Urgent Care Claims, the Claims Administrator will accept either oral or written requests for appeals for an expedited review. All necessary information may be transmitted between the Claims Administrator and you or health program providers by telephone, fax or other available expeditious methods.

Notice of Decision on Appeal

After your appeal is reviewed by the Claims Administrator, you will receive a notice of decision on appeal within the timeframes specified below.

The timeframes for providing a notice of decision on appeal generally start when a written appeal is received by the Claims Administrator. Notice of decision on appeal may be provided in writing through in-hand, mail, or electronic delivery. Urgent care decisions may be delivered by telephone, facsimile, or other expeditious methods. Note, “days” means calendar (not business) days. The timeframes for providing a notice of decision on appeal are as follows:

- **Urgent Care Appeals.** As soon as possible considering the medical urgency but not later than 72 hours after the Claims Administrator receives your appeal.
- **Pre-Service Appeals.** Within a reasonable period of time appropriate to the medical

circumstances but not later than 30 days after the Claims Administrator receives your appeal.

- **Post-Service Appeals.** Within a reasonable period of time appropriate to the medical circumstances but not later than 60 days after the Claims Administrator receives your appeal.

Your Right to Information

Upon request to the applicable Claims Administrator listed in [Appendix D](#), and free of charge, you have a right to reasonable access to and copies of all documentation, records, and other information relevant to the Claims Administrator’s denial of a claim or appeal. Information is “relevant” if it:

- was relied upon in making the decision on your claim or appeal;
- was submitted to, considered, or generated by the Claims Administrator in considering your claim or appeal; or
- demonstrates compliance with the Claims Administrator’s administrative processes for making claim decisions.

You are also entitled to access and copy any internal rule, guideline, protocol, or other similar criteria used as a basis for a decision on your denied claim or appeal upon request, free of charge. Similarly, if your claim or appeal is denied based on a determination involving a medical judgment, you are entitled to an explanation of the scientific or clinical reasons for that determination free of charge upon request. (A medical judgment includes whether a treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate.) In addition, if voluntary appeals or alternative dispute resolution options are available under the Benefit Program, you are entitled to receive information about the procedures for using these alternatives.

Non-Health Benefit Claims and Appeals Procedures

Filing an Initial Claim

You (or your beneficiaries) must follow the claims rules established by the various non-health Benefit Programs. If you are required to file an initial claim for benefits, you must do so within the time specified by the Benefit Program and in accordance with the program's established claim procedures. See the applicable Benefit Program material listed in [Appendix C](#) for details on filing claims. See [Appendix D](#) for a list of claim administrators and their contact information.

Appeals Procedures

Definitions

- **Claim.** A request for program benefits made to the proper person in accordance with the Claims Administrator's claims filing procedures. Claims must be submitted in writing to the appropriate Claims Administrator listed in [Appendix D](#).
- **Adverse Decision or Adverse Decision on Appeal.** A denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a benefit.
- **Authorized Representative.** An individual authorized to act on your behalf in pursuing a claim or appeal, in accordance with procedures established by the Claims Administrator. For information about appointing an authorized representative, contact the Claims Administrator listed in [Appendix D](#).

Notice of Adverse Decision

If your claim is denied or reduced, you will be provided with a notice of adverse decision.

For the AD&D and Legal programs, the notice of adverse decision will be provided within 90 days after the date your claim is first filed with the Claims Administrator. If more time is needed by the Claims Administrator to make a decision, you will be notified of the reasons for the delay before the end of the initial 90-day period. The Claims Administrator may extend the decision-making period for up to 90 days if the program's Claims

Administrator determines that special circumstances require an extension.

Appeal of Adverse Decision

If you disagree with the decision on your claim, you (or your authorized representative) may file a written appeal, with the applicable Claims Administrator. For a list of Claims Administrators, see [Appendix D](#).

For the AD&D and Legal programs, the appeal must be filed within 60 days after you receive the notice of adverse decision.

You should include the reasons you believe the claim was improperly denied and all additional facts and documentation you consider relevant in support of your appeal. If you don't appeal on time, you may lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a requirement before you can sue in court).

The decision will consider all comments, documentation, and records and other information you submit, even if they were not submitted or considered during the initial claim decision.

Notice of Decision on Appeal

For the AD&D and Legal programs, the Claims Administrator will provide notice of its decision within 60 days after the date you file the appeal. The Claims Administrator may extend the decision-making period for up to 60 days if special circumstances require extra time. You will be notified of the extension prior to the end of the first 60-day period.

The notice of extension will indicate the special circumstances requiring an extension and the date by which the Claims Administrator expects to render the determination on review.

Your Right to Information

Upon request to the applicable Claim Administrator listed in [Appendix D](#), and free of charge, you have a right to reasonable access to and copies of all documentation, records, and other information relevant to the Claims Administrator's denial of a claim or appeal. Information is "relevant" if it:

- was relied upon in making the decision on your claim or appeal;
- was submitted to, considered, or generated by the Claims Administrator in considering your claim or appeal; or
- demonstrates compliance with the Claim Administrator's administrative processes for making claim and appeal decisions.

If a voluntary appeals process or alternative dispute resolution is available under the Benefit Program, you will receive information about such procedures.

If your claim or appeal is denied based on a determination involving a medical judgment, you are entitled to an explanation of the scientific or clinical reasons for that determination free of charge upon request. (A medical judgment includes whether a treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate.)

[Section 12. Your Rights and Privileges Under ERISA](#) in this document provides additional information on legal action you can take if you feel your right to a benefit has been improperly denied.

Procedures for Issues, Questions or Disputes That Are Not Subject to ERISA's Claims Regulations

If you have an issue or dispute regarding the Plan that is not considered a "claim" for benefits under ERISA (e.g., eligibility for Plan benefits or COBRA or the applicability of the Plan's right of reimbursement or subrogation), you must notify LLNS by contacting the Customer Care Center and explain your issue or dispute. You must provide LLNS with any information you think supports your position and any other information LLNS determines is necessary to decide your issue or dispute.

If LLNS makes a decision that is adverse to you, you will be provided with a notice of adverse decision no later than 90 days after you provide LLNS with all of the information it needs to decide your issue or dispute. LLNS may extend the decision-making period for up to 90 additional days if it determines that special circumstances require an extension.

If you disagree with LLNS' decision, you (or your authorized representative) may file a written appeal to LLNS. Any appeal must be filed no later than 60 days after you receive the notice of adverse decision.

You should include the reasons you believe the decision was improper and all additional facts and documentation you consider relevant in support of your appeal. If you don't appeal on time, you may not file suit in any court, as you will not have exhausted your internal administrative appeal rights.

The decision will consider all comments, documentation, and records and other information you submit, even if they were not submitted or considered during the initial claim decision.

LLNS will provide notice of its decision on your appeal within 60 days after the date you file the appeal and provide all information necessary to decide your appeal. LLNS may extend the decision-making period for up to 60 days if special circumstances require extra time.

No suit may be filed in any court regarding any question, issue or dispute under the Plan without first exhausting these administrative procedures. Any such suit must be brought not later than 12 months after the date LLNS renders its final decision on your appeal.

9. Continuation of Health Care Coverage

COBRA Continuation Coverage

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, you or your dependents may be eligible to continue your health Benefit Program coverage (called “COBRA coverage”) at group rates. Health Benefit Program coverage includes medical and dental benefits.

COBRA coverage is available in certain instances, called “qualifying events,” where health Benefit Program coverage would otherwise end. You may elect to continue coverage at your own expense on an after-tax basis when the coverage that you have through the Plan ends. The coverage described below may change as permitted or required by changes in any applicable law.

The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of COBRA. In some states, state law provisions may also apply to the insurers offering benefits under the Plan.

You don't have to show that you're insurable to choose COBRA coverage. However, COBRA coverage is provided subject to your eligibility for coverage as described below. LLNS reserves the right to terminate your coverage retroactively if it's determined that you're ineligible under the terms of the Plan.

Cost of COBRA Coverage

You will be required to pay up to 102% of the cost of COBRA coverage. If your coverage is extended from 18 months to 29 months for disability, you will be required to pay up to 150% of the cost of COBRA coverage beginning with the 19th month of coverage.

The cost of group health coverage periodically changes. If you elect COBRA coverage, the COBRA Administrator will notify you of changes in the cost. Premiums are established in a 12-month determination period and will increase

during that period if the Plan has been charging less than the maximum permissible amount, or if the qualified beneficiary changes coverage level.

The initial payment for COBRA coverage is due 45 days from the date of your election.

Thereafter, you must pay for coverage on a monthly basis. You have a grace period of at least 30 days.

COBRA Administrator

If you have any questions about COBRA coverage or the application of the law, contact the COBRA Administrator listed in [Appendix F](#).

You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website at www.dol.gov/ebsa.

Your Obligation to Notify the COBRA Administrator

You must notify the COBRA Administrator in writing immediately at the address listed below if:

- your marital status has changed;
- you, your spouse or a dependent has changed address; or
- a dependent loses eligibility for dependent coverage under the terms of the Plan.

All written notices and other communications regarding COBRA coverage for your health Benefit Programs should be directed to the COBRA Administrator listed in [Appendix F](#).

Who is eligible for COBRA?

Spouses

If you're the spouse (as defined under federal law) of a retiree and you're covered by a health Benefit Program on the day before the qualifying event, you're considered a qualified beneficiary. That means you have the right to choose COBRA coverage for yourself if you lose coverage under the terms of the health Benefit Program for any of the following reasons:

- your spouse dies; or

- you divorce or legally separate from your spouse (this includes a divorce or legal separation that occurs after the employee drops you from coverage, if the employee acted in anticipation of the divorce or legal separation).

Dependent children

If you're a dependent child of a retiree and you're covered under a health Benefit Program on the day before the qualifying event, you're also considered a qualified beneficiary. This means you have the right to COBRA coverage if you lose coverage under the terms of the health Benefit Program for any of the following reasons:

- the retiree (your parent) dies; or
- you cease to be a "dependent child" under the health Benefit Program.

Continuation Coverage for Domestic Partners

Although continuation coverage for domestic partners and their dependents is not required by federal COBRA, LLNS currently provides continuation coverage to domestic partners and their dependent children who were covered under the health programs when group coverage would otherwise have been lost. In the description of federal COBRA above, whenever the term:

- "Spouse" is used and wherever "qualified beneficiary" when referring to a spouse is used, the term "domestic partner" as defined by the Plan also generally applies.
- Wherever the terms "dependent child" or "dependent children" are used, or wherever "qualified beneficiary (ies)" when referring to a dependent child or dependent children is used, the dependent child/children of a domestic partner also generally applies.
- Wherever the term "divorce" is used, termination of domestic partnership also generally applies.
- Wherever the term "COBRA continuation coverage" is used, continuation coverage also generally applies.

Your duties

You must inform the COBRA Administrator of a divorce, legal separation, termination of domestic partnership, or child's loss of dependent status under the health Benefit Program, or the retiree's death in writing if you wish to preserve the right to elect COBRA coverage. You must provide notice within 60 days from the latest of (1) the date of the retiree's death, divorce, legal separation, termination of domestic partnership, or loss of dependent status, or (2) the date coverage is lost because of the event.

Notice must be provided to the COBRA Administrator on a form which can be obtained by calling the COBRA Administrator. The notice should then be completed and provided to the COBRA Administrator at the address listed in [Appendix F](#).

The notice must identify the qualified beneficiary requesting COBRA coverage and the qualifying event that gave rise to the individual's right to COBRA coverage. In addition, the qualified beneficiary may be required to provide the COBRA Administrator with documentation supporting the occurrence of the qualifying event.

If you fail to notify the COBRA Administrator within this 60-day period, the right to elect COBRA coverage will be lost.

When the COBRA Administrator is notified that one of these events has happened, the COBRA Administrator will in turn notify you about your right to choose COBRA coverage.

LLNS' duties

Qualified beneficiaries will be notified of the right to elect COBRA coverage if they lose coverage under the terms of the health Benefit Program because of any of the following events:

- the retiree dies; or
- LLNS experiences a bankruptcy.

Electing COBRA

To elect or inquire about COBRA coverage, contact the COBRA Administrator listed in [Appendix F](#).

Under the law, you have 60 days to elect COBRA coverage measured from the date you would lose your active coverage because of one of the events described earlier, or, if later, 60 days after you receive notice of your right to elect COBRA coverage. A qualified beneficiary who doesn't choose COBRA coverage within the time period described above loses the right to elect COBRA coverage. The qualified beneficiary will be required to reimburse the Plan for any claims mistakenly paid after the date coverage would normally have ended.

If you choose COBRA coverage, your coverage will be the same coverage you had immediately before the event and the same coverage that is being provided to similarly situated beneficiaries. "Similarly situated" refers to a current retiree or dependent who hasn't had a qualifying event.

You'll have the same opportunity to change health Benefit Program coverage as similarly situated active retirees have, e.g., at annual open enrollment or if you gain a new dependent. This also means that if the coverage for similarly situated retirees or family members is modified, your coverage will be modified. Your COBRA rights are provided as required by law. If the law changes, your rights will change accordingly.

Separate elections

Each qualified beneficiary has the right to elect COBRA coverage. This means that a dependent child can elect COBRA coverage even if the covered spouse chooses not to. A covered spouse may elect COBRA coverage on behalf of other qualified beneficiaries, and a parent or legal guardian may elect COBRA coverage on behalf of a minor child.

Length of COBRA coverage

If elected, COBRA coverage begins on the date the qualified beneficiary's retiree coverage ends. For dependents who no longer satisfy the requirements for dependent coverage, COBRA coverage begins on the first day of the month following the date of the qualifying event. However, coverage won't take effect unless COBRA coverage is elected as described above and the required premium is received.

COBRA coverage for your covered spouse and dependents will continue for up to 36 months if coverage would otherwise end because of:

- the retiree's death;
- you divorce or legal separation from the retiree;
- the dependent child losing eligibility for coverage; or

In the unlikely event that LLNS commences Chapter 11 bankruptcy proceedings in federal court, the retiree will be eligible for COBRA coverage until his or her death, as long as LLNS maintains any group health plan. The retiree's covered surviving spouse and dependent children will be covered during that period, and will be entitled to an additional 36 months of COBRA coverage after the retiree's death.

Early termination of COBRA coverage

COBRA coverage will terminate before the expiration of the period described above for any of the following reasons:

- LLNS no longer provides group health coverage to any of its employees; or
- the premium for COBRA coverage isn't paid on time (within the applicable grace period); or
- the qualified beneficiary becomes covered – after the date COBRA coverage is elected – under another group health plan that doesn't contain any applicable exclusion or limitation for any pre-existing condition of the individual; or
- the qualified beneficiary first becomes entitled to Medicare after the date COBRA coverage is elected; or
- coverage has been extended for up to 29 months due to disability, and the Social Security Administration has made a final determination that the individual is no longer disabled; or
- for any reason the Plan would terminate coverage of a participant or dependent who is not receiving COBRA coverage (such as fraud).

Benefit Program Changes During COBRA

While on COBRA coverage, there may be changes to the medical or dental Benefit Programs, such as new deductibles, covered expenses, or changes to your premiums. All changes will also apply to your COBRA coverage.

HIPAA Certificate of Creditable Coverage

When your COBRA coverage ends, you may receive a certificate of creditable coverage that:

- confirms that you had whatever medical coverage you continued through COBRA; and
- states how long you were covered.

If you become eligible for other medical coverage that excludes or delays coverage for certain pre-existing conditions, you can use this certificate to receive credit – against the new program’s pre-existing condition limit – for the time you were covered by the Plan. You may also use this certificate to enroll in other group or individual insurance coverage.

In addition to the certificate you receive automatically, you also may request an additional certificate by contacting your medical benefit program claims administrator at the number listed in [Appendix C](#) within 24 months after coverage ends.

Conversion privileges

Some health programs that are provided pursuant to group insurance contracts or policies offer the right to convert group coverage to individual coverage when coverage ends.

Medical Benefits. When medical coverage ends for you or any eligible dependent covered by a LLNS-sponsored insured medical program, you may be able to apply for an individual medical policy from the carrier that provides benefits under that insured medical program.

The coverage and benefits may not be the same as those provided by LLNS-sponsored medical programs and the rates will vary depending on your age, where you live and other factors.

For additional information on your conversion rights, you should check with your medical benefit provider, or refer to the appropriate Benefit Program material listed in [Appendix C](#).

Note: You may also be able to purchase an individual policy from an insurance carrier other than the provider for the LLNS-sponsored program that provides the coverage that you are losing.

You should examine your conversion coverage and all other options carefully before declining conversion coverage. You should be aware that companies selling individual health insurance may require a review of your medical history that could result in a higher premium - or you could be denied coverage entirely.

Behavioral Health Benefits. There is no stand-alone conversion coverage available for behavioral health benefits. However, if you convert the medical benefits to which the behavioral health benefit is attached, behavioral health benefit may be converted as well.

Dental and Vision Benefits. There is no conversion coverage available for dental and vision benefits.

Right to Individual Health Coverage

Under HIPAA, if you are an “eligible individual,” you have a right to buy certain individual health policies (or in some states, to buy coverage through a highrisk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan;
- Your most recent coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

10. Coordination of Health Care Benefits

When You Have Other Coverage

The procedures and timeframes described in this section are the general coordination of benefit rules applicable to LLNS health benefits.

The coordination of benefits rules applicable to you will be those of the Benefit Program in which you are enrolled and will be furnished automatically to you without charge as a part of the applicable Benefit Program Summary. See [Appendix C](#).

If you do not receive the coordination of benefits procedures as a part of the Benefit Program material for medical or dental benefits, please contact the Customer Care Center in [Appendix F](#).

If you and your dependents are enrolled in a LLNS health Benefit Program as well as another employer-sponsored health program, such as your spouse's health program at work, the LLNS-sponsored program coordinates its coverage with the other program. The LLNS-sponsored program also coordinates its coverage with Medicare.

Here's how it works in general:

- When the program pays first, in other words, if the LLNS-sponsored program is the "primary" program, it pays benefits as though no other program exists. The other program may or may not pay benefits.
- When the LLNS-sponsored program pays second, in other words, if the LLNS-sponsored program is the "secondary" program, it may or may not pay a benefit, depending on what the other program (the "primary" program) has paid. The most an enrolled person can receive is a combined total of 100% of eligible expenses from both programs.

Which Plan Pays First?

If you or your covered dependents are also covered under another health program, the first

of the following rules which applies determines which program is primary:

1. A program without a coordination of benefits provision is considered primary.
2. A program that covers the person as an employee or as a dependent is primary to a plan which covers the person as a retiree or as a dependent of a retiree. The program that covers the person as a retiree or as a dependent of a retiree (for example, as the spouse of a retiree) is secondary.

However, this order of payment is reversed in certain cases when the person is a Medicare beneficiary. If (due to federal law) Medicare is secondary to the plan covering the person as a dependent, and Medicare is primary to the plan covering the person as a non-dependent, then the plan covering the person as a non-dependent (for example, a retiree) pays secondary and the other plan (for example, the plan of the retiree's working spouse) pays primary.

3. For a dependent child whose parents are married or are living together, whether or not they have ever been married, or if a court decree establishes joint custody of your child without specifying which parent is responsible to provide health coverage, LLNS uses the "birthday rule" to determine which program pays benefits first when your child is covered under both parents' programs. Under the birthday rule, the program covering the parent whose birthday falls first in the calendar year is primary. The program of the parent whose birthday falls later in the year is the secondary program.

If both parents share the same birthday, the primary program will be the program that has covered one parent the longest. The secondary program will be the program that has covered the other parent for a shorter period of time.

4. For a dependent child whose parents are divorced or separated or are not living together, whether or not they were ever married, and the children are covered under both parents' programs, the birthday rule does not apply. Instead, LLNS uses the

following rules to determine which program pays benefits first:

- First, the program of the parent to whom the court specifically assigned financial responsibility for health care expenses (for instance, through a Qualified Medical Child Support Order),
 - Then, the program of the parent who has custody,
 - Then, the program of the spouse married to the parent who has custody,
 - Then, the program of the parent who does not have custody, and
 - Finally, the program of the spouse married to the parent who does not have custody.
5. A program in which you are enrolled as an active employee (or as that employee's dependent) rather than as a laid-off or retired employee is primary.
 6. In most cases, a program in which you are enrolled as an active employee or subscriber rather than as a COBRA participant is primary.
 7. The program covering the individual for the longest period of time is considered primary.
 8. If none of the above rules determines which program is primary, the allowable expenses shall be shared equally between the programs.

Coordination of Benefits with Medicare

If you are eligible for Medicare, you must enroll in Medicare Part A and B and you may continue your medical coverage under a LLNS program. Medicare will then be primary and pay benefits first for:

- Eligible retirees age 65 and over and spouses age 65 and over who participate in the LLNS program on the basis of the retiree's former employment status with UC or LLNS.
- Social Security disabled individuals who are covered by the LLNS program on the basis of retiree's former employment status with UC or LLNS and who are entitled to Medicare benefits (e.g., disabled spouses or

dependents of an active employee, or Social Security disabled participants who have returned to work).

- For certain individuals who become eligible for Medicare on the basis of having end-stage renal disease (ESRD), regardless of the reason for the employer coverage, or whether they are eligible for Medicare on the basis of age or disability, after the first 30 months of Medicare entitlement due to ESRD.

When, under the Medicare Secondary Payer rules Medicare is the primary payer, benefits payable under the LLNS medical Benefit Programs will be reduced by any amounts that would be paid by Medicare Part A, Part B, or the Part D prescription drug benefit (except as otherwise provided in the last paragraph of this section). This reduction applies for any participant or beneficiary who is eligible for Medicare*, and for any item or service that is or would be covered by Medicare, and whether or not:

- the person is actually enrolled in Parts A and B and D of Medicare; or
- a claim for the service is filed with Medicare; or
- the service is provided under a private contract with a physician who has elected to opt out of the Medicare system; or
- the person is enrolled in a Medicare Advantage plan to receive Medicare benefits, and receives unauthorized services (out-of-network services not covered by the plan); or
- the person is enrolled in any other Medicare related demonstration or other pilot program.

For any period the employer receives payments with respect to a Part D-eligible individual in LLNS' capacity as a sponsor of a qualified retiree prescription drug plan under 42 C.F.R. 423.880-894, payments won't be reduced by amounts that would be payable under Medicare Part D with respect to expenses incurred for such period by such individuals.

* Retirees who were retired from the University of California-LLNL and age 65 as of June 30, 1991, are not subject to the requirement that they be enrolled in Medicare Part A and B.

11. General Plan Provisions

Administration of Plan

The Plan Administrator has absolute discretionary authority to control and manage the operation and administration of the Plan, to correct errors, and to construe and interpret the provisions under the Plan, including but not limited to determinations regarding eligibility and benefits. The Plan Administrator may delegate duties and responsibilities as it deems appropriate to facilitate the day-to-day administration of the Plan and, unless the Plan Administrator expressly provides to the contrary, any such delegation will carry with it the Plan Administrator's full discretionary authority to accomplish the delegation.

Plan Amendment and Termination

LLNS or its authorized delegate reserves the right in its sole discretion to amend in writing the Plan, or any Benefit Program, in whole or in part, and/or to completely discontinue the Plan or any Benefit Program at any time. LLNS' decision to amend or terminate is not a fiduciary decision. It is a business decision that can be made solely in LLNS' interest. No benefits under the Plan vest. Hence, no participant, dependent or beneficiary has a vested right to any benefits under the Plan.

LLNS or its authorized delegate may terminate or partially terminate the Plan, or discontinue contributions at any time. In addition, LLNS reserves the right to amend or terminate covered expenses, benefit co-payments, and reserves the right to amend the programs to require or increase participant contributions. LLNS also reserves the right to amend the programs to implement any cost control measures that it may deem advisable.

Insured Benefits

Certain benefits under this Plan are fully insured. The insurance companies that provide insured benefits under the Plan have been delegated the full discretionary authority to administer the benefits they provide by the Plan. See [Appendix](#)

[E](#) for information on which health and welfare Benefit Programs are insured.

With respect to insured benefits, claims for benefits are sent to the insurance company. In this case, the insurance company is responsible for paying claims, not LLNS.

The insurance company is responsible for and has full discretionary authority for:

- Determining eligibility for and the amount of any benefits payable under the applicable Benefit Program.
- Prescribing claims and appeal procedures to be followed and the claims and appeal forms to be used by plan participants pursuant to the applicable program.

The insurance company also has the authority to require plan participants to furnish it with such information as it determines necessary for the proper administration of the applicable program.

With respect to insured benefits, you (or, in the case of your death, your beneficiary as that term is defined in the applicable insurance policy or contract) will be entitled to receive only the insured benefit for which provision is actually made under the insurance policy or contract.

LLNS does not assume or have any liability or responsibility for any insured benefit and you will be able to look only to the insurance contracts for payment or any benefits. You will not have any claim for insured benefits against LLNS, the Plan Administrator or any employee, officer or director of LLNS.

Contributions and Premiums

LLNS' Contributions

LLNS may fund benefits provided under the Plan in whole or in part. Contributions made by LLNS will be made at the times and in the manner determined by LLNS. No assets will be set aside for the purpose of providing benefits under the Plan. LLNS will pay benefits (including any insurance premiums necessary for the purchase of benefits) required under the Plan out of the general assets of LLNS. In no event shall LLNS have any obligation to fund self-funded benefits provided under the Plan in advance of the date that such benefits are payable or pre-pay the

premiums or other fees required in order to provide insured benefits under the Plan. LLNS' contribution, if any, may be paid directly to the insurance company or other provider under the Plan. Such payment shall constitute a complete discharge of the liability of the Plan.

Self Funded Benefits

LLNS' general assets are the sole source of self-funded benefits under the Plan. LLNS assumes no liability or responsibility for payment of such benefits beyond that which is provided in the self-funded Benefit Programs.

No Right to Assets

No participant, dependent, or beneficiary shall have any right to, interests in or claim for any particular assets of LLNS, the Plan, any Benefit Program or any underlying contract, trust or other funding vehicle.

Acts of Third Parties

When you or your covered dependent ("you") are injured or become ill because of the actions or inactions of a third party, the Plan may cover your eligible health care (medical, prescription drug, dental and vision) expenses. However, to receive coverage, you must notify the Plan that your illness or injury was caused by a third party, and you must follow special Plan rules. This section describes the Plan's procedures with respect to subrogation and right of recovery.

Subrogation means that if an injury or illness is someone else's fault, the Plan has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the Plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party related to the illness or injury.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that the Plan has rights of recovery, reimbursement and subrogation to the extent of any benefits paid for an illness or injury that is caused by a third party. You also agree that the Plan:

- Has an equitable lien, including an equitable lien by contract, on any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;
- May appoint you as constructive trustee for any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury; and
- May bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the sickness or injury.

If you (or your attorney or other representative) receive any payment from the sources listed later in this section – through a judgment, settlement or otherwise – for an illness or injury that is caused by a third party, you agree to have the funds in a separate, identifiable account by you or the holder of the funds and that the Plan has an equitable lien on the funds, and you agree to serve as a constructive trustee over the funds to the extent that the Plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must pay the Plan back first, in full, out of such funds for any expenses the Plan has paid related to such illness or injury. You must pay the Plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses and regardless of any doctrines that may affect the Plan's right of recovery or reimbursement, including, but not limited to, the "make-whole doctrine."

Furthermore, you must pay the Plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury. If any money is left over, you may keep it.

Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) you incur in obtaining the funds.

The Plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

- Money from a third party that you, your guardian or other representatives receive or are entitled to receive;
- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive;
- Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid; and
- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives.

As a Plan participant, you are required to:

- Cooperate with the Plan's efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan's subrogation or recovery rights outlined in this Summary.
- Notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.
- Provide all information requested by the Plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.

- Execute and deliver such documents as may be required and do whatever else is needed to secure the Plan's rights.

The Plan may terminate your Plan participation and/or offset your future benefits for the value of benefits advanced to you that the Plan does not recover, if you do not provide the information, authorizations, or to otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan.

If the subrogation provisions in these "Acts of Third Party" provisions conflict with subrogation provisions in an insurance contract governing benefits at issue, the subrogation provisions in the insurance contract will govern. If the right of recovery provisions in these "Acts of Third Party" provisions conflict with right of recovery provisions in an insurance contract governing benefits at issue, the right of recovery provisions in the insurance contract will govern.

All Plan rights under this section remain enforceable against the heirs and estate of any covered person.

No Estoppel of Plan

No person is entitled to any benefit under the Plan or any Benefit Program except and to the extent expressly provided under the Plan or the Benefit Program. The fact that payments have been made from the Plan or Benefit Program in connection with any claim for benefits under the Plan or Benefit Program does not (a) establish the validity of the claim, (b) provide any right to have such benefits continue for any period of time, or (c) prevent the Plan or Benefit Program from recovering the benefits paid to the extent that the Plan Administrator ultimately determines that there in fact was no right to payment of the benefits under the Plan or Benefit Program.

Thus, if a benefit is paid to a person under the Plan or Benefit Program and it is thereafter determined by the Plan Administrator that such benefit should not have been paid (whether or not attributable to an error by such person, the Plan Administrator or any other person), then the Plan Administrator may take such action as it deems necessary or appropriate to remedy such situation, including without limitation, by

deducting the amount of any such overpayment from any succeeding payments to or on behalf of such person under the Plan or Benefit Program or from any amounts due or owing to such person by a Participating Employer or under any other plan, program or arrangement benefiting the employees or former employees of a Participating Employer, or otherwise recovering such overpayment from whoever has benefited from it.

Responsibility for Benefit Programs

Please note that:

- All service providers are independent contractors of the applicable program; LLNS is not responsible for their actions.
- Neither the Plan Administrator nor LLNS is responsible for the fiscal viability of benefit providers or for the continuing participation of doctors, hospitals, and others in their networks.
- Neither the Plan Administrator nor LLNS can warrant or guarantee the quality or the length of service of providers.

No Guarantee of Employment

By adopting and maintaining the Plan and these Benefit Programs, LLNS has not entered into an employment contract with any person. Nothing in the Plan documents gives any plan participant the right to be employed by LLNS or interferes with LLNS' right to discharge any plan participant at any time. Similarly, these programs do not give LLNS the right to require any employee to remain employed by LLNS, or to interfere with an employee's right to terminate employment with LLNS at any time.

Assignment of Benefits

Except as otherwise may be required under a qualified medical child support order (QMCSO) which assigns benefits to a child who has been designated as an alternate recipient in accordance with the Plan's QMCSO procedures; by applicable law; or as otherwise specifically provided in the Plan or Benefit Program material; neither you, your dependents nor your

beneficiaries may assign, sell, transfer, pledge, charge, encumber or allow the attachment or alienation of any amount payable to you, your spouse, dependents, or any beneficiaries at any time under the Plan. Any attempt to assign, sell, transfer, pledge, charge, encumber or allow the attachment or alienation of any such amount, whether presently or thereafter payable will be void. If you, your spouse, dependent, or beneficiary attempt to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber any amount payable under the Plan, or any part thereof, or if a person's bankruptcy or other event would cause amounts payable under the Plan to be subject to the person's debts or liabilities, then the Plan Administrator may direct that such amount be withheld and that the same or any part thereof be paid or applied to or for the benefit of you, your spouse (as defined under federal law) or your dependents, or any of them in such manner and proportion as the Plan Administrator may deem proper. Such payment shall constitute a complete discharge of the liability of the Benefit Program and the Plan.

However, you may request and authorize the Plan Administrator or the appropriate insurance company or service provider to pay benefits directly to the hospital, physician, dentist or other person furnishing services or supplies covered under the applicable Benefit Program and any such payment, if made, shall constitute a complete discharge of the liability of the Benefit Program and the Plan.

If the Plan Administrator determines that an underpayment of benefits has been made, the Plan Administrator shall take such action as it deems necessary or appropriate to remedy such situation. However, in no event shall interest be paid on the amount of any underpayment.

LLNS Use of Funds

To the maximum extent permitted by applicable law, LLNS shall be entitled to retain any policy dividend or refund, or portion thereof, it receives from any insurance company, administrative services organization, HMO, service plan or any other organizations or individuals, that exceeds the amount necessary to fund the benefits provided by any particular Benefit Program and Benefit Program expense.

Plan's Use of Funds

All amounts paid to and held by the Plan (or any trust established in connection with the Plan), as well as any policy dividends and/or refunds not belonging to LLNS, shall be available without limit to fund the benefits provided by any Benefit Program included in the Plan or any Benefit Program added to the Plan. To the maximum extent permitted by applicable law, the Plan Administrator, at its sole and unfettered discretion, may use funds accumulated under this Plan for any Benefit Program (whether funds accumulated from insurance contract reserves, insurance company refunds or dividends, participant or LLNS contributions, or administrative fees) to reduce the level of contributions that LLNS would otherwise make to the Plan for any Benefit Program. Such use of funds may occur without there being any effect on the participant contributions otherwise applicable.

Workers' Compensation

The Plan is not in lieu of, and does not affect any requirement for coverage by workers' compensation insurance.

Withholding of Taxes

Withholding may be applied to amounts paid or payable pursuant to this Plan for all federal, state, local, or other taxes with respect to any amounts paid or payable under this Plan or any Benefit Program.

12. Your Rights and Privileges under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). The Benefit Programs maintained by LLNS that are governed by ERISA include those described in this SPD, except for the Dependent Care Reimbursement Account (a non-ERISA program).

ERISA provides that all Plan participants have the right to:

Receive Information About Your Plan and Benefits

- You can examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites) all documents governing the Plan. This includes insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- By submitting a written request to the Plan Administrator, you can obtain copies of documents governing the operation of the Plan, including insurance contracts, copies of the latest annual report (Form 5500 Series), and an updated summary plan description. (The administrator can charge you a reasonable fee for the copies.)
- You should receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to provide a copy of this summary annual report to each Plan participant.

Continue Group Health Plan Coverage

You can continue health care coverage (medical and dental) for yourself, spouse, and/or your dependents if there is a loss of coverage under the Benefit Program as a result of a qualifying event. You and your dependents may have to

pay for such coverage. For more details, review [Section 9. Continuation of Health Care Coverage](#), the relevant Benefit Program materials, and the COBRA notice that was mailed to your home. If you need another copy of any of these documents, please contact the COBRA Administrator located in [Appendix F](#).

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate your Plan prudently and in the interest of you and other Plan participants and beneficiaries. No one, including LLNS, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right (within certain time schedules) to:

- know why this was done,
- obtain copies of documents relating to the decision without charge, and
- appeal any denial.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive your copies within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

After exhausting your appeal rights, you may file suit in a state or federal court if you have a claim for benefits which is denied or ignored, in whole or in part. You may file suit in a federal court if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order.

You may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court if:

- Plan fiduciaries misuse the Plan's money, or
- You are discriminated against for asserting your rights.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200

Constitution Avenue N.W., Washington, D.C. 20210 or www.askebsa.dol.gov. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 800-444-EBSA (3272) or on the internet at www.dol.gov/ebsa.

Additional Information

Additional pertinent information is attached as follows:

[Appendix A: Premium Contribution Arrangements](#)

[Appendix B: Surviving Family Members Eligibility](#)

[Appendix C: Benefit Program Materials](#)

[Appendix D: Claim and Appeals Administration Information](#)

[Appendix E: Funding and Contract Administration Information](#)

[Appendix F: Customer Care Center and COBRA Administrator](#)

[Appendix G: Plan Administration Information](#)

Appendix A: Premium Contribution Arrangements

The following chart indicates who pays for the premiums for each Benefit Program – you and LLNS, LLNS alone or you alone. To determine whether you are eligible to participate in a particular Benefit Program, refer to [Section 2. Eligibility Requirements](#). For enrollment information, refer to [Section 3. How to Enroll](#).

ELIGIBILITY CATEGORIES A-D (See Section 2 for Eligibility Rules)	LLNS CONTRIBUTIONS TO RETIREE WELFARE BENEFITS	
<i>Service Credits⁴ for LLNS Contributions (if any)</i>	Medical and Dental	Legal, Vision and AD&D
A. Be a former employee of the University of California (UC) at Lawrence Livermore National Laboratory (LLNL) (or current or surviving family member of such former UC-LLNL employee) who is receiving or is eligible to receive retiree welfare benefits from UC on September 30, 2007. <i>Service Credits⁴ are based on years of service with UC.</i>	<p><u>Non-Medicare Eligible Retirees</u></p> <p>LLNS contribution is determined by applying a service-based factor ("Service Credits") to the maximum LLNS contribution, as follows:</p> <ul style="list-style-type: none"> ▪ 0-4 years of Service Credit - 0% LLNS contribution. ▪ 5-9 of Service Credit <ul style="list-style-type: none"> - if meet the Rule of 75 - 50% LLNS contribution - if do not meet the Rule of 75 - 0% LLNS contribution ▪ 10 years of Service Credit - 50% LLNS contribution (except E. below). ▪ 11-20 - 50% LLNS contribution - increases in 5% increments, up to 100%. <p><u>Medicare-Eligible Retirees</u></p> <p>the LLNS contribution is an annual flat dollar amount contribution to a Health Reimbursement Arrangement (HRA) for each Medicare eligible retiree and/or dependent(s).</p> <p><u>Special Rules</u></p> <ul style="list-style-type: none"> ▪ UC Transitioning Employees¹ who properly elected TCP1 or TCP2 upon transfer to LLNS, and who were hired in a career position with UC before January 1, 1990, and who have not had a break in service, receive 100% of the LLNS maximum contribution. The Rule of 75³ does not apply. ▪ Retirees who, immediately before retirement, were receiving a monthly disability benefit under the LLNS Defined Benefit Eligible Disability Program continue with a 50% LLNS contribution even if they have less than 10 years of service. Upon retirement, the Service Credit earned while on disability status counts toward determining the percentage of the LLNS contribution toward medical and dental coverage. 	<p>No LLNS contribution to legal or AD&D. Access only.</p> <p>No LLNS contribution to vision. Access to discounts only.</p>
B. Be a former employee of UC at LLNL who terminated from UC before October 1, 2007, and who, within 120 days of termination from UC elected to receive a monthly pension from the University of California Retirement Plan (UCRP). <i>Service Credits⁴ are based on years of service with UC.</i>		
C. Be a former employee of LLNS who is a UC Transitioning Employee ¹ who properly elected TCP1, and who is vested with 5 years of Service Credits ⁴ and is eligible to receive a monthly disability benefit under the LLNS Defined Benefit Eligible Disability Program and who applies for welfare benefits within 120 days of termination from LLNS. <i>Service Credits⁴ are based on years of service with UC frozen upon transfer to LLNS on October 1, 2007, and years of service at LLNS beginning October 1, 2007. The Rule of 75³ does not apply.</i>		
D. Be a former LLNS employee who retires from a benefits eligible appointment at LLNS on or after October 1, 2007 and who applies for LLNS Health and Welfare benefits within 120 days of termination from LLNS, <i>and who is</i>		
1. a UC Transitioning Employee ¹ who properly elected TCP1 and is receiving a monthly pension from the LLNS Defined Benefit Pension Plan; <i>or</i> <i>Service Credits⁴ are based on years of service with UC frozen upon transfer to LLNS on October 1, 2007, and years of service at LLNS beginning October 1, 2007.</i>		
2. a UC Transitioning Employee ¹ who properly elected TCP2 who is receiving a monthly pension from the UCRP; <i>or</i> <i>Service Credits⁴ are based on years of service with UC frozen upon transfer to LLNS on October 1, 2007.</i>		
3. a Direct Transfer Employee ² hired on or after October 1, 2007; <i>or</i> <i>Service Credits⁴ are based on years of Qualifying Service with a LLNS Parent Company and/or Affiliate frozen upon transfer to LLNS on date of hire at LLNS. Qualifying Service for this purpose is as defined in Section H-35 of DOE Contract No. DE-AC52-07NA27344, Modification No.: M003, Section H-35 (7). NOTE: Most Direct Transfer Employees will be eligible for access only health care since relatively few such employees have the requisite Qualifying Service.</i>		
4. a LLNS employee hired on or after October 1, 2007 who is not a Direct Transfer Employee ² .	No LLNS contribution. Access only.	
E. Be a former employee of LLNS who is a UC Transitioning Employee ¹ who elected a lump sum payment through the UCRP and who retires from a benefits eligible appointment at LLNS on or after October 1, 2007, and who applies for LLNS Health and Welfare benefits within 120 days of termination from LLNS.	No LLNS contribution. Access only.	

¹ A UC Transitioning Employee means an employee of LLNS who joined LLNS on October 1, 2007, and was employed by the University of California (UC) on September 30, 2007.

² A Direct Transfer Employee means an employee of LLNS who transfers to LLNS directly from UC (excluding UC-LLNL), Bechtel, BWXT or The Washington Group (LLNS Parent Companies) or directly from an Affiliate of a LLNS Parent Company. An Affiliate of a LLNS Parent Company is any company partially or fully owned by a LLNS Parent Company (excluding UC-LLNL).

³ The Rule of 75 means your age (in whole years) plus Service Credits equal 75.

⁴ Service Credits means years of service calculated by and transferred to LLNS from any LLNS Parent Company and/or for service with LLNS on or after October 1, 2007, years of service calculated by LLNS generally based on the methodology used to calculate Credited Service under the LLNS Defined Benefit Pension Plan (whether or not the employee is eligible for the LLNS Defined Benefit Pension Plan).

Appendix B: Surviving Family Members Welfare Benefits

Medical, Dental, and Legal Coverage

To be eligible for medical, dental and/or legal survivor benefits under this Plan, the surviving family member must have been enrolled in the medical, dental and/or legal benefit program under this Plan on the date of death of the Deceased.

Under certain circumstances*, to be eligible, the surviving spouse or domestic partner must also be named as a Contingent Annuitant under either the UCRP or the LLNS Defined Pension Plan, as applicable.

If the eligible surviving family member is not enrolled in the medical, dental and/or legal benefit program under this Plan on the date of death of the Deceased, the surviving family member must wait until an Involuntary Loss of Other Coverage (ILOC) to enroll in the benefit(s) in which he or she is not enrolled on the date of death. There is no later opportunity for enrollment at Open Enrollment.

Initially, coverage is limited to the benefit(s) (medical, dental and/or legal) in which the family member was enrolled on the date of death of the Deceased. However, if a benefit in which the family member is enrolled is offered during a subsequent Open Enrollment a surviving family member can change options within such benefit and add such eligible family members as may be permitted under this Appendix B.

Note: The adult family member who is enrolled at the date of death of the deceased, is the *only* adult who will be eligible for LLNS-sponsored coverage thereafter (for example, coverage may not be switched from the deceased's adult dependent relative to the surviving spouse). A surviving spouse or domestic partner may not enroll a new spouse or domestic partner in LLNS-sponsored benefits, except for Accidental Death and Dismemberment (AD&D).

Please see footnotes below for definitions that apply to this Appendix B.

LLNS Contribution toward Medical and Dental Premiums for Survivors

For surviving family members eligible for continued medical and dental coverage, the level of LLNS maximum contribution is based on the Service Credits³ of the Deceased as earned under the rules set forth in [Section 2](#) and [Appendix A](#) of this SPD. The percentage corresponds to the Deceased's years of Service Credits³ as shown below. *

Deceased's Years of Service Credit ³	0–9	10	11	12	13	14	15	16	17	18	19	20+
Percentage of LLNS Contribution	Not eligible	50%	55%	60%	65%	70%	75%	80%	85%	90%	95%	100%

* **Exceptions** to the LLNS contributions set forth above: Eligible survivors of the following will receive 100% of the LLNS maximum contribution toward the medical and/or dental premiums.

- A Retiree from the University of California (UC) at Lawrence Livermore National Laboratory (LLNL) whose membership in the UCRP began before January 1, 1990, without a break in service from the UCRP;
- A LLNS employee, disabled former employee, or retiree who is a UC Transitioning Employee¹ who properly elected **TCP1** who dies at age 50 or more with at least 5 years of Service Credits³ and whose membership in the UCRP began before January 1, 1990, without a break in service from either the UCRP or the LLNS Defined Benefit Pension Plan.

*See *LLNS Survivor Welfare Benefits Eligibility Chart* below for additional eligibility requirements.

LLNS SURVIVOR WELFARE BENEFIT ELIGIBILITY CHART

LLNS CATEGORIES	SURVIVING FAMILY MEMBERS WHO MAY BE ELIGIBLE FOR WELFARE BENEFITS See Footnotes to Appendix B, below, for additional eligibility criteria.
Deceased Employee	
TCP1	
A current LLNS employee who is a UC Transitioning Employee ¹ who properly elected TCP1 who at any age with at least 2 but less than 5 years of Service Credits ³ and upon whose death the employee's family member(s) are eligible for the LLNS Defined Benefit Survivor Income Benefit Program.	<ul style="list-style-type: none"> ▪ Eligible Spouse⁴ ▪ Eligible Domestic Partner⁴ ▪ Eligible Child⁴
A current LLNS employee who is a UC Transitioning Employee ¹ who properly elected TCP1 who dies at age 50 or more with at least 5 years of Service Credits ³ and upon whose death the employee's family member(s) are eligible for the LLNS Defined Benefit Survivor Income Benefit Program or LLNS Defined Benefit Joint and Survivor benefit.	<ul style="list-style-type: none"> ▪ Surviving Spouse⁴ ▪ Surviving Domestic Partner⁴ ▪ Surviving Child⁴
TCP2	
A current LLNS employee who is a UC Transitioning Employee ¹ who properly elected TCP2 who dies at age 50 or more with at least 5 years of Service Credits ³ and upon whose death the employee's family member is eligible for a survivor income under the UCRP.	<ul style="list-style-type: none"> ▪ Surviving Spouse⁴ ▪ Surviving Domestic Partner⁴ ▪ Surviving Child⁴
A Direct Transfer Employee ² who dies at age 50 or more with at least 5 years of service credit and TCP2 hired October 1, 2007 or later.	<ul style="list-style-type: none"> ▪ Surviving Spouse⁴ ▪ Surviving Domestic Partner⁴ ▪ Surviving Child⁴

Deceased Former Employee	
TCP1	
A former LLNS employee who is a UC Transitioning Employee ¹ who properly elected TCP1 who dies within 120 days of termination from LLNS at age 50 or more with at least 5 years of Service Credits ³ and whose surviving family members have had continuous coverage under LLNS Health and Welfare benefits from the date of termination to the date of death.	<ul style="list-style-type: none"> ▪ Surviving Spouse⁴ ▪ Surviving Domestic Partner⁴ ▪ Surviving Child⁴
A former LLNS employee who is a UC Transitioning Employee ¹ who properly elected TCP1, who dies before age 50 with at least 5 years of Service Credits ³ and is eligible to receive a monthly disability benefit under the LLNS Defined Benefit Eligible Disability Program and who applied for LLNS Health and Welfare benefits within 120 days of termination from LLNS and whose surviving family members have had continuous coverage under the LLNS Health and Welfare benefits from the date of termination to the date of death and upon whose death the Employee's family members are eligible for the LLNS Defined Benefit Survivor Income Benefit Program.	<ul style="list-style-type: none"> ▪ Eligible Spouse⁴ ▪ Eligible Domestic Partner⁴ ▪ Eligible Child⁴
A former LLNS employee who is a UC Transitioning Employee ¹ who properly elected TCP1, and who dies at age 50 or more with at least 5 years of Service Credits ³ and is eligible to receive a monthly disability benefit under the LLNS Defined Benefit Eligible Disability Program and who applied for LLNS Health and Welfare benefits within 120 days of termination from LLNS and whose surviving family members have had continuous coverage under the LLNS Health and Welfare benefits from the date of termination to the date of death and upon whose death the Employee's family members are eligible for the LLNS Defined Benefit Survivor Income Benefit Program.	<ul style="list-style-type: none"> ▪ Surviving Spouse⁴ ▪ Surviving Domestic Partner⁴ ▪ Surviving Child⁴

TCP2	
A former LLNS employee who is a UC Transitioning Employee ¹ who properly elected TCP2 who dies within 120 days of termination from LLNS at age 50 or more with at least 5 years of Service Credits ³ and whose surviving family members have had continuous coverage under LLNS Health and Welfare benefits from the date of termination to the date of death.	<ul style="list-style-type: none"> ▪ Surviving Spouse⁴ ▪ Surviving Domestic Partner⁴ ▪ Surviving Child⁴

Deceased Retiree	
A former employee of the University of California (UC) at Lawrence Livermore National Laboratory (LLNL) who terminated from UC before October 1, 2007, upon whose death the spouse or domestic partner is eligible for a monthly survivor benefit from a pension plan due to service with LLNL.	<ul style="list-style-type: none"> ▪ Surviving Spouse⁴ ▪ Surviving Domestic Partner⁴ ▪ Surviving Child⁴
A former LLNS employee who terminated from a benefits eligible appointment at LLNS on or after October 1, 2007, and who applies for LLNS Health and Welfare benefits within 120 days of termination from LLNS, <i>and who</i> is either: <ul style="list-style-type: none"> ▪ A UC Transitioning Employee¹ who properly elected TCP1, who is receiving a monthly pension from the LLNS Defined Benefit Pension Plan and who, upon retirement properly elected a monthly pension with his or her spouse or domestic partner, as the case may be, designated as the Contingent Annuitant; <i>or</i> ▪ A UC Transitioning Employee¹ who properly elected TCP2 who is receiving a monthly pension from the UCRP and who, upon retirement properly elected a monthly pension and upon whose death the Retiree's surviving family members are eligible for a survivor income under the UCRP. 	<ul style="list-style-type: none"> ▪ Surviving Spouse⁴ ▪ Surviving Domestic Partner⁴ ▪ Surviving Child⁴
A Direct Transfer Employee ² who is receiving monthly pension from a parent company defined benefit plan with his or her spouse or domestic partner, as the case may be, designated as a contingent annuitant.	<ul style="list-style-type: none"> ▪ Surviving Spouse⁴ ▪ Surviving Domestic Partner⁴ ▪ Surviving Child⁴

Footnotes to Appendix B

¹ A UC Transitioning Employee means an employee of LLNS who joined LLNS on October 1, 2007, and was employed by the University of California (UC).

² A Direct Transfer Employee means an employee of LLNS who transfers to LLNS directly from UC (excluding UC-LLNL), Bechtel, BWXT or The Washington Group (LLNS Parent Companies) or directly from an Affiliate of a LLNS Parent Company. An Affiliate of a LLNS Parent Company is any company partially or fully owned by a LLNS Parent Company (excluding UC LLNL).

³ Service Credits means years of service calculated by and transferred to LLNS from any LLNS Parent Company and/or for service with LLNS on or after October 1, 2007, years of service calculated by LLNS generally based on the methodology used to calculate Credited Service under the LLNS Defined Benefit Pension Plan (whether or not the employee is eligible for the LLNS Defined Benefit Pension Plan).

⁴ Definitions

Deceased Deceased means, for purposes of this Appendix B, the Deceased Employee, Deceased Former Employee or the Deceased Retiree of UC or LLNS, as applicable, as set forth in the *LLNS Survivor Welfare Benefit Eligibility Chart* above, upon whose death certain eligible family members may be eligible for welfare benefits under this Plan.

Deceased Disabled A participant in the LLNS Defined Benefit Disability Benefit Program or a participant in the UCRP receiving disability benefits.

Disability

To determine eligibility as a disabled spouse, domestic partner, or child, disability is defined as a medically determinable physical or mental impairment which prevents the individual from engaging in "substantial gainful activity" on the basis of qualified medical opinion. "Substantial gainful activity" means any type of gainful activity commensurate with age, education skills or general background, which could reasonably be expected to result in earnings in excess of the Social Security Administration's annually published dollar amount used to determine substantial gainful activity.

Eligibility is determined by the Plan Administrator, and the spouse, domestic partner, or child must cooperate with all requests for information, including medical information. The disability must be expected to continue for an extended and uncertain period of time. For a disabled spouse or domestic partner, the disability must exist at the time of the Deceased's death. For a disabled child, the disability must have arisen while the child was otherwise eligible, i.e., under age 26.

Eligible Child

The natural or adopted child or stepchild of a Deceased or the natural or adopted child of the Deceased's domestic partner. The child must have received at least 50 percent support from the Deceased for the one year period ending on: a) in the case of a Deceased Employee, the Deceased's date of death; b) in the case of a Deceased Disabled, the Deceased's disability date; or c) in the case of a Deceased Retiree, the Deceased's retirement date. On the date of the Deceased's death, the child must be:

- under age 18,
- under age 22 and attending an educational institution full time, or
- disabled (see "Disability" above); the disability must have occurred while the child was eligible based on age, as listed above.

The one-year support requirement does not apply to the Deceased's natural child born within 10 months after the Deceased's death or to the Deceased's natural child born less than one year before the Deceased's death. A stepchild or domestic partner's child must have been living with or in the care of the Deceased just before the Deceased's death.

Eligible Domestic Partner

The domestic partner of the Deceased established pursuant to the *LLNS Declaration of Domestic Partnership*. The partnership must have been established for the one year period ending on: a) in the case of a Deceased Employee, the Deceased's date of death; b) in the case of a Deceased Disabled, the Deceased's disability date; or c) in the case of a Deceased Retiree, the Deceased's retirement date, and the partner must:

- be responsible for the care of an Eligible Child;
- be Disabled (see above); or
- have reached age 60.

If the domestic partner is responsible for the care of an Eligible Child who is the Deceased's natural child, the one-year domestic partnership requirement is waived.

If the Deceased was an employee or a disabled former employee eligible to retire (age 50 or more with at least 5 years of Service Credits³) or a retiree, the domestic partner may be eligible to receive benefits as a Surviving Domestic Partner; see below.

Eligible Spouse The widow or widower of a Deceased. The date of the marriage must have been at least one year before: a) in the case of a Deceased Employee, the Deceased's date of death; b) in the case of a Deceased Disabled, the Deceased's disability date; or c) in the case of a Deceased Retiree, the Deceased's retirement date, and the spouse must:

- be responsible for the care for an Eligible Child;
- be disabled (see above); or
- have reached age 60. (The qualifying age is 50 for a widow if (a) the spouse and Deceased were married before October 19, 1973, and (b) the Deceased had entered UCRP by that date.)

If the spouse is responsible for the care of an eligible child who is the Deceased's natural child, the one-year marriage requirement is waived.

If the deceased was an employee or a disabled former employee eligible to retire (age 50 or more with at least 5 years of Service Credits³) or a retiree, the widow or widower may be eligible to receive benefits as a Surviving Spouse; see below.

Eligible Survivor See "Eligible Spouse," "Eligible Domestic Partner," "Eligible Child," or "Eligible Dependent Parent."

Surviving Child Child up to age 26 covered by deceased at date of death. Deceased employee must have been eligible to retire (Age 50 or more with at least 5 years of service credit) at time of death.

Surviving Domestic Partner The domestic partner of a Deceased established pursuant to the *LLNS Declaration of Domestic Partnership*. The Surviving Domestic Partner is eligible to receive the survivor benefits without qualifying as an Eligible Domestic Partner under the following conditions:

- Deceased Employee — the Deceased must have been eligible to retire (age 50 or more with at least 5 years of Service Credits³) at the time of death.
- Deceased Disabled Former Employee — the Deceased must have been eligible to retire (age 50 or more with at least 5 years of Service Credits³) at the time of death.
- Deceased Retiree — the surviving domestic partner must have been in a relationship with the Deceased for at least one year before the Deceased's retirement date and continuously until the Deceased's death.

Surviving Spouse The widow or widower of a Deceased. The Surviving Spouse is eligible to receive the survivor welfare benefits without qualifying as an Eligible Spouse under the following conditions:

- Deceased Employee — the Deceased must have been eligible to retire (age 50 or more with at least 5 years of Service Credits³) at the time of death.
- Deceased Disabled Former Employee — the Deceased must have been eligible to retire (age 50 or more with at least 5 years of Service Credits³) at the time of death.
- Deceased Retiree — the Surviving Spouse must have been married to the Deceased for at least one year before the Deceased's retirement date and continuously until the Deceased's death.

If Coverage Ends

If you were covered by LLNS-sponsored welfare benefits, but you are *not* eligible for welfare benefits as a surviving family member, coverage stops on the last day of the last month for which premiums were paid.

You may be eligible to continue or convert your coverage.

Health coverage. For continuation of health care coverage options, please see [Section 8](#).

Legal coverage. You may be able to convert your group legal coverage to an individual policy within 31 days of the date group coverage ends. Contact ARAG for more information. See [Appendix E](#).

Appendix C: Benefit Program Materials

The following supplemental Benefit Program Materials, together with any updates (including any Summary of Material Modifications SMMs) and open enrollment materials are hereby incorporated herein by reference into the SPD and the Plan.

Medical	Benefit Program Material
Anthem Blue Cross of California	
Anthem Blue Cross PLUS	Employees and Retirees in California without Medicare Evidence of Coverage and Disclosure Form
	Employees and Retirees Outside of California without Medicare Evidence of Coverage and Disclosure Form
	CVS/Caremark (Prescription Drug Benefit)
Anthem Blue Cross EPO	Employees and Retirees in California without Medicare Evidence of Coverage and Disclosure Form
	Employees and Retirees Outside of California without Medicare Certificate of Insurance
	CVS/Caremark (Prescription Drug Benefit)
Anthem Blue Cross PPO	Employees and Retirees in California without Medicare Evidence of Coverage and Disclosure Form
	Employees and Retirees Outside of California without Medicare Certificate of Insurance
	CVS/Caremark (Prescription Drug Benefit)
Anthem Blue Cross Core Value	Employees and Retirees in California without Medicare
	Employees and Retirees Outside of California without Medicare
	CVS/Caremark (Prescription Drug Benefit)
Kaiser	
Kaiser California (Non Medicare)	Kaiser Permanente Traditional Plan Evidence of Coverage for Lawrence Livermore National Security LLC, Northern California Kaiser Permanente Traditional Plan Evidence of Coverage for Lawrence Livermore National Security LLC, Southern California
Kaiser Senior Advantage Medicare	Kaiser Permanente Senior Advantage with Part D Evidence of Coverage for Lawrence Livermore National Security, LLC, Northern California Kaiser Permanente Senior Advantage with Part D Evidence of Coverage for Lawrence Livermore National Security, LLC, Southern California
Dental	
Benefit Program Material	
Delta Dental of California PPO	LLNS Employees, Retirees and their Dependents Delta Dental PPO Evidence of Coverage and Disclosure Statement
DeltaCare [®] USA DMO	DeltaCare [®] USA Dental Health Care Program for Eligible Employees, Eligible Retirees and Dependents Combined Evidence of Coverage and Disclosure Statement
Legal	
ARAG [®] Legal Plan	The ARAG [®] Legal Benefit Program LLNS Benefit Program Summary
Accidental Death & Dismemberment (AD&D)	
Benefit Program Material	
AIG Benefit Solutions	AIG Benefit Solutions Voluntary Group Accident Insurance Program Designed for the Eligible Retired Persons (Retirees) of LLNS

Please contact your Benefit Program listed in [Appendix E](#) if you do not receive the Benefit Program Summary for the program in which you are enrolled.

Appendix D: Claim and Appeals Administration Information

Please direct all claims and claim appeals to the claims administrator for the Benefit Program in which you are enrolled.

Unless otherwise specifically indicated below, the Claims Administrator listed below has full discretionary authority to administer and interpret the Benefit Program in question and to determine eligibility for participation and for benefits under the terms of that Benefit Program.

Benefit Program	Claims Administrator
Medical	
Anthem Blue Cross of California	
Blue Cross PLUS <ul style="list-style-type: none"> ▪ Employees and Retirees in California without Medicare ▪ Employees and Retirees Outside of California without Medicare 	Anthem Blue Cross of California P.O. Box 60007 Los Angeles, CA 90060-0007 877-359-9654
<ul style="list-style-type: none"> ▪ CVS/Caremark (Prescription Drug Benefit) 	CVS/Caremark Appeals Department, MC109 P.O. Box 52084 Phoenix, AZ 85072-2084 Fax: 1-866-443-1172, Attn: Urgent Appeals
Anthem Blue Cross PPO <ul style="list-style-type: none"> ▪ Employees and Retirees in California without Medicare ▪ Employees and Retirees Outside of California without Medicare 	Anthem Blue Cross of California P.O. Box 60007 Los Angeles, CA 90060-0007 877-359-9654
<ul style="list-style-type: none"> ▪ CVS/Caremark (Prescription Drug Benefit) 	CVS/Caremark Appeals Department, MC109 P.O. Box 52084 Phoenix, AZ 85072-2084 Fax: 1-866-443-1172, Attn: Urgent Appeals
Anthem Blue Cross EPO <ul style="list-style-type: none"> ▪ Employees and Retirees in California without Medicare ▪ Employees and Retirees Outside of California without Medicare 	Anthem Blue Cross of California P.O. Box 60007 Los Angeles, CA 90060-0007 877-359-9654
<ul style="list-style-type: none"> ▪ CVS/Caremark (Prescription Drug Benefit) 	CVS/Caremark Appeals Department, MC109 P.O. Box 52084 Phoenix, AZ 85072-2084 Fax: 1-866-443-1172, Attn: Urgent Appeals
Anthem Blue Cross Core Value <ul style="list-style-type: none"> ▪ Employees and Retirees in California without Medicare ▪ Employees and Retirees Outside of California without Medicare 	Anthem Blue Cross of California P.O. Box 60007 Los Angeles, CA 90060-0007 877-359-9654
<ul style="list-style-type: none"> • CVS/Caremark (Prescription Drug Benefit) 	CVS/Caremark Appeals Department, MC109 P.O. Box 52084 Phoenix, AZ 85072-2084 Fax: 1-866-443-1172, Attn: Urgent Appeals

Benefit Program	Claims Administrator	
Kaiser <ul style="list-style-type: none"> ▪ Kaiser Traditional Plan ▪ Kaiser Senior Advantage with Part D 	Northern California Region Members: Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 12923 Oakland, CA 94604-2923	Southern California Region Members: Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 7004 Downey, CA 90242-7004
Dental Delta Dental PPO	Claims: Delta Dental of California P.O. Box 99730 Sacramento, CA 95899-7330 800-777-5854 www.deltadentalca.org	Appeals: Attn: Customer Service Department P.O. Box 99730 Sacramento, CA 95899-7330 800-777-5854 www.deltadentalca.org
DeltaCare® USA	Claims: Claims Department 12898 Towne Center Dr. Cerritos, CA 90703 800-422-4234 CS-Cerritos@delta.org	Appeals: Attn: Customer Service Department P.O. Box 99730 Sacramento, CA 95899-7330 800-777-5854 www.deltadentalca.org
Legal ARAG®	ARAG® P.O. Box 9171 Des Moines, IA 50306-9171 tel: 800-247-4184 fax: 515-246-8710 Service@ARAGgroup.com http://members.ARAGgroup.com/llns	
Accidental Death & Dismemberment (AD&D) AIG Benefit Solutions	AIG Benefit Solutions Domestic Claims Accident & Health Claims Department P.O. Box 25987 Shawnee Mission, KS 66225-5987 800-551-0824 302-661-8940	

Appendix E: Funding and Contract Administration/ Insurance Company Information

Unless otherwise specifically indicated below, the Contract Administrator or insurance company listed below has full discretionary authority to administer and interpret the Benefit Program in question and to determine eligibility for participation and for benefits under the terms of that Benefit Program.

BENEFIT PROGRAM	CONTACT INFORMATION	TYPE OF FUNDING
Medical		
Anthem Blue Cross of California		
Anthem Blue Cross PLUS <ul style="list-style-type: none"> ▪ Employees and Retirees in California without Medicare ▪ Employees and Retirees Outside of California without Medicare 	Anthem Blue Cross of California 21555 Oxnard Street Woodland Hills, CA 91367 877-359-9654	self-funded
<ul style="list-style-type: none"> ▪ CVS/Caremark (Prescription Drug Benefit) 	CVS/Caremark P.O. Box 52196 Phoenix, AZ 85072-2196 tel: 1-866-623-1438 http://www.caremark.com/	self-funded
Anthem Blue Cross PPO <ul style="list-style-type: none"> ▪ Employees and Retirees in California without Medicare ▪ Employees and Retirees Outside of California without Medicare 	Anthem Blue Cross of California 21555 Oxnard Street Woodland Hills, CA 91367 877-359-9654	self-funded
<ul style="list-style-type: none"> ▪ CVS/Caremark (Prescription Drug Benefit) 	CVS/Caremark P.O. Box 52196 Phoenix, AZ 85072-2196 tel: 1-866-623-1438 http://www.caremark.com/	self-funded
Anthem Blue Cross EPO <ul style="list-style-type: none"> ▪ Employees and Retirees in California without Medicare ▪ Employees and Retirees Outside of California without Medicare 	Anthem Blue Cross of California 21555 Oxnard Street Woodland Hills, CA 91367 877-359-9654	self-funded
<ul style="list-style-type: none"> ▪ CVS/Caremark (Prescription Drug Benefit) 	CVS/Caremark P.O. Box 52196 Phoenix, AZ 85072-2196 tel: 1-866-623-1438 http://www.caremark.com/	self-funded
Anthem Blue Cross Core Value <ul style="list-style-type: none"> ▪ Employees and Retirees in California without Medicare ▪ Employees and Retirees Outside of California without Medicare 	Anthem Blue Cross of California 21555 Oxnard Street Woodland Hills, CA 91367 877-359-9654	self-funded
<ul style="list-style-type: none"> • CVS/Caremark (Prescription Drug Benefit) 	CVS/Caremark P.O. Box 52196 Phoenix, AZ 85072-2196 tel: 1-866-623-1438 www.caremark.com	self-funded

Kaiser		
<ul style="list-style-type: none"> ▪ Kaiser California (Non Medicare) ▪ Kaiser Senior Advantage Medicare 	Kaiser Foundation Health Plan, Inc. Special Services Unit P.O. Box 23280 Oakland, CA 94623 800-464-4000 800-777-1370 (hearing impaired) http://kp.org	insured
Dental		
Delta Dental PPO	Delta Dental of California P.O. Box 997330 Sacramento, CA 95899-7330 800-777-5854 http://deltadentalca.org	insured
DeltaCare® USA	DeltaCare USA 12898 Towne Center Dr. Cerritos, CA 90703 800-422-4234 http://www.deltadentalca.org/deltacareusa	insured
Legal		
ARAG®	ARAG® P.O. Box 9171 Des Moines, IA 50306-9171 tel: 800-247-4184 fax: 515-246-8710 Service@ARAGgroup.com http://members.ARAGgroup.com/llns	insured
Accidental Death & Dismemberment (AD&D)		
AIG Benefit Solutions	AIG Benefit Solutions Domestic Claims Accident & Health Claims Department P.O. Box 25987 Shawnee Mission, KS 66225-5987 800-551-0824 302-661-8940	insured

Appendix F: Customer Care Center and COBRA Administrator

Customer Care Center	Empyrean Customer Care Center 1-844-750-5567 www.llnsretireebenefits.com
OneExchange	OneExchange Medicare Benefits Advisors 1-866-682-4841 https://medicare.oneexchange.com
COBRA Administrator	Empyrean Customer Care Center 1-844-750-5567 www.llnsretireebenefits.com

Appendix G: Plan Administration Information

Official Plan Name	LLNS Health and Welfare Benefit Plan for Retirees (See Appendix C for a listing of Benefit Programs applicable to this SPD).	
Employer/Plan Sponsor	Lawrence Livermore National Security, LLC	<p>Mailing Address P.O. Box 808, L-644 Livermore, CA 94551</p> <p>Street Address 7000 East Ave., L-644 Livermore, CA 94550</p>
Employer I.D. Number (EIN)	20-5624386	
Plan Number	502	
Type of Administration/ Insurance Issuers	The Benefit Programs are provided under both self-funded and insured arrangements. The insured programs are provided under group contracts between LLNS and the carriers. The carriers – not LLNS – have full discretionary authority to determine eligibility for benefits, the amount of any benefits payable, and for prescribing the claims procedures for the insured programs.	
Plan Funding Medium	The insured arrangements are paid by insurance policies. The benefits and other costs (such as administrative costs) for the self-funded programs and insurance premiums for the insured benefits are paid from the general assets of LLNS.	
Plan Administrator	Lawrence Livermore National Security, LLC Benefits and Investment Committee	<p>Mailing address: P.O. Box 808, L-644 Livermore, CA 94551</p> <p>Street Address: 7000 East Ave., L-644 Livermore, CA 94550</p>
Claims Administrator	See Appendix D	
Agent for Service of Legal Process	Lawrence Livermore National Security, LLC Service of legal process may also be made upon the Plan Administrator (see above).	<p>Mailing Address P.O. Box 808, L-701 Livermore, CA 94551</p> <p>Street Address 7000 East Ave., L-701 Livermore, CA 94550</p>
Plan Year	Generally, January 1 – December 31 (First Plan Year is October 1 – December 31)	
Contribution Sources	LLNS and participant contributions	