Open Enrollment Period

October 24 - November 11, 2016

2017 Employee Open Enrollment Guide

LLNL Benefits

Designed for Life

If you are enrolled in Medicare or will become eligible to enroll in Medicare in the next 12 months (during 2017), a Federal law gives you more choices about your prescription drug coverage. Please see page 15 for more details.

The information and descriptions in this Enrollment Guide are intended to be a summary of available benefits so you can consider alternatives suitable to your personal circumstances and requirements.

For plans governed by ERISA, this 2017 Open Enrollment Guide is a Summary of Material Modifications to the LLNS Health and Welfare Benefit Plan for Employees (January 2013). LLNS reserves the right to amend or discontinue any benefit plan at any time. If there is a conflict between this Summary and the terms of the Plan document, the Plan document will govern.

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HIGHLIGHTS OF CHANGES FOR 2017

Medical

Kaiser
- No plan design changes for 2017

Anthem Blue Cross EPO
- No plan design changes for 2017

Anthem Blue Cross Plus
- No plan design changes for 2017

Anthem Blue Cross PPO
- No plan design changes for 2017

Anthem Blue Cross Core Value
- 2017 HSA employee contribution limits are $2,650 for employee only coverage; $5,250 for family, an increase of $50 for employee only coverage

Anthem Blue Cross High Deductible Health Plan (HDHP)
- 2017 HSA employee contribution limits are $2,650 for employee only coverage; $5,250 for family, an increase of $50 for employee only coverage

Vision

- Buy-up option being offered (see page 22 for details)
- LLNS still pays 100% for base plan

Legal

- Legal insurance will be open for new enrollments this Open Enrollment
- New benefits include Tax Services and Credit Records Correction

Health Care Reimbursment Account (HCRA)

- To participate in 2017, you must enroll during Open Enrollment, even if you are contributing in 2016
- HCRA contribution limit will remain $2,550 in 2017
- Expenses may only be incurred 1/1/17 through 12/31/17; 2017 paper claims must be submitted by 3/31/18

Dependent Care Reimbursement Account (DCRA)

- To participate in 2017, you must enroll during Open Enrollment, even if you are contributing in 2016
- Limit remains $5,000 in 2017 ($2,500 if married and filing separately)
- Expenses may only be incurred 1/1/17 through 12/31/17; 2017 claims must be submitted by 3/31/18

There are no plan designs or rate changes to the Dental, Life Insurance, Supplemental Disability, or AD&D plans in 2017.

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IMPORTANT: Details are contained in the medical plan comparison chart that begins on page 18. Be sure to carefully review this information.

Anthem Blue Cross Plus, PPO, and Core Value Deductibles

Anthem Blue Cross will keep track of two different types of health insurance deductibles for each family member: the individual deductible and the family deductible. When a family member has had enough personal health care expenses that he or she has met the individual deductible amount, Anthem Blue Cross begins paying for this person's expenses, but not the health care expenses of other family members. If other family members have paid enough in individual deductibles that added together the family deductible has been met; Anthem Blue Cross begins paying the health care expenses for the entire family, even the family members that haven't paid anything at all toward their individual deductible. This process is known as an embedded deductible.

LAPIS: MAKING CHANGES TO YOUR BENEFITS ONLINE

Review your current enrollment information. Log onto LAPIS. To view current enrollment information, click on Confirmation Statement from the Self Service Benefits menu.

- Take a close look at the plans offered in 2017, evaluate plan coverages, and select the one that suits you and your family best. You can get information from the health plans' website or contact the health plan directly for assistance locating providers, covered medications and for any other specific questions you may have.
- Remember to enroll in the Health Care Reimbursement Account (HCRA) and the Dependent Care Reimbursement Account (DCRA) if you want to participate in 2017.
- Carefully review the costs of each plan—costs include your payroll deduction amounts plus your out-of-pocket costs—what you pay when you receive care (for example, deductibles, co-payments, etc.).

Use the Online Tools to Help

- Review information available on the Open Enrollment web site accessible from the front page of MyLLNL.
- Use LAPIS to:
    - » check your current enrollments
    - » make any Open Enrollment transactions
    - » verify that your beneficiary designations are up-to-date
    - » confirm LLNS has your correct emergency contacts, home address and telephone numbers

Enroll Using LAPIS

- LAPIS is located at **https://lapis.llnl.gov** and is accessible from a Laboratory computer or through VPN. If you don't have access to a computer, workstations are available at the following site locations:
    - » Benefits Office–B543, R1216
    - » Main Library–T4727, Information Desk
    - » Training Center–T1879 (call 4-3948 to arrange a time)
- Log onto LAPIS Self Service and click on the Benefits link under the Benefits topic from the navigation menu.
- You will receive a confirmation email the day after you have submitted your changes. Click the link to review your confirmation statement.
- Make sure the confirmation statement reflects your coverages correctly. Be sure to keep your confirmation statement. It can serve as backup for proof of eligibility or coverage.
- During Open Enrollment you can make changes as often as you like.

Open Enrollment transactions must be made before 5:00 p.m. (PT) Friday, November 11, 2016.

Please note: Each time you click "Submit," a new confirmation email will be generated. The last confirmation statement on record as of 5:00 p.m. (PT) on November 11, 2016 will be applied.

If you wish not to change any of your enrollments, you do not need to make any changes during Open Enrollment, **except if you are participating in the HCRA and/or DCRA**—then you must re-enroll in these plans to continue participation in 2017.

ENROLLING IN OR CHANGING YOUR BENEFIT ELECTIONS

Open Enrollment is the only time during the calendar year when you can make changes to your medical, dental, or vision coverage, enroll/re-enroll in the HCRA and/or DCRA plans, unless you experience a Qualifying Life Event.

Actions You Can Take During Open Enrollment

- Change to a different medical plan
- Change to a different dental plan (California residents only)
- Opt out of your medical, dental, and/or vision plan; or enroll in a plan if you previously opted out
- Enroll eligible family members in your health plans
- Cancel health plan coverage for currently enrolled family members
- Enroll or re-enroll in the Health Care Reimbursement Account (HCRA)—if currently enrolled, you must re-enroll for 2017 to continue contributing
- Enroll or re-enroll in the Dependent Care Reimbursement Account (DCRA)—if currently enrolled, you must re-enroll for 2017 to continue contributing

Actions Permitted Outside Open Enrollment (Qualifying Life Event)

You are allowed to change your benefit elections outside of Open Enrollment if certain events occur and if you make the change within 31 days of the event. Generally, the event must affect eligibility and the election change must be on account of and correspond with the event. In compliance with Section 125 of the IRS Code, medical, dental, vision, and spending account plan elections may be changed during the calendar year only if you have a Qualifying Life Event. Such events include:

- a change in your legal marital status, including marriage, divorce, death of your spouse, domestic or civil union partner, legal separation, or annulment;
- a change in the number of your tax dependents including through birth, adoption, placement for adoption, or death;
- termination or commencement of employment by you, your spouse, domestic partner, or dependent;
- an event that changes your, your spouse's, or your other dependent's employment status that results in gaining or losing eligibility for coverage;
- your dependent's ability or inability to satisfy dependent eligibility requirements;
- a change in residence or work site by you, your spouse, domestic or civil union partner, or dependent that causes a loss of access to providers in your HMO plan's network.

PLEASE NOTE: If you do not notify the Benefits Office within 31 days of the event, you will not be able to add a dependent or make any other coverage changes until the next Open Enrollment Period, with benefits coverage effective the following January 1.

Disability and life insurance coverage can be changed at any time during the year. Changes to these plans are not available on Self Service during Open Enrollment. At any time, if you want to enroll in or increase your disability coverage or your life insurance coverage, you must submit a Statement of Health to the applicable insurance carrier. Your application must be approved by the carrier before the coverage change goes into effect. Contact the Benefits Office to make changes to these plans.

For more information see the LLNS Health and Welfare Benefit Plan for Employees Summary Plan Description (January 2013) located at **https://benefits.llnl.gov/health-welfare/summary-plan**.

Dependent Eligibility

If an enrolled family member loses eligibility during the year, you are responsible for de-enrolling that family member. Don't wait until Open Enrollment. A child who turns 26 is automatically de-enrolled by LLNS (legal wards are de-enrolled at 18). You are responsible for costs incurred in connection with the enrollment of ineligible family members and you could be subject to penalties associated with the misuse of the plan if you continue coverage for family members who no longer meet LLNS eligibility rules. For more information see the LLNS Health and Welfare Benefit Plan for Employees Summary Plan Description (January 2013). Questions about eligibility should be directed to the Benefits Office at 925-422-9955.

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If you are covering a dependent child whose eligibility requires tax dependency and tax dependency is lost at any time, promptly notify the Benefits Office at 1-925-422-9955.

HEALTH, DENTAL, AND VISION CARE

Medical Benefit Choices

You are encouraged to evaluate your options to ensure that the choices you made for the current year still make sense for 2017. Plan rates are on page 8. A medical plan comparison chart to help facilitate a comparison of the plans begins on page 18. Plans available for 2017 include:

- **Kaiser Permanente CA**
- **Anthem Blue Cross EPO**
- **Anthem Blue Cross Plus**
- **Anthem Blue Cross PPO**
- **Anthem Blue Cross HDHP (High Deductible Health Plan) with HSA**
- **Anthem Blue Cross Core Value with HSA**

Health Savings Account (HSA)

If you enroll in either the HDHP or Core Value medical plan options, you will also be eligible for the HSA that accompanies these options. Additional information can be found at **https://benefits.llnl.gov/**.

LLNS will make contributions to the HSA on your behalf. In addition, you will be able to make before-tax* contributions to your HSA up to IRS limits. You can make your HSA before-tax contributions via payroll deduction or directly to your HSA on an after-tax basis and claim them on your tax return.

Please note that if you enroll in the HDHP or Core Value medical plan options, you will not be eligible for the Health Care Reimbursement Account (HCRA).

The HSA can be used to pay for qualified medical, prescription, dental, and vision expenses. It can also be used to pay for qualified expenses for dependents not enrolled in a LLNS medical, dental, or vision plan as long as the dependent is a qualified dependent under IRS rules (IRC Section 152).

IRS HSA Contribution Limits*	
Self-only Coverage	**Family Coverage**
$3,400	**$6,750**
*Employees age 55 or older can contribute an additional $1,000	

2017 HSA Contributions (Based on a full calendar year)			
LLNS HSA Contribution		**Maximum Employee HSA Contribution**	
Employee Only Coverage	**Family Coverage**	**Employee Only Coverage**	**Family Coverage**
$750	**$1,500**	**$2,650**	**$5,250**
*Employees age 55 or older can contribute an additional $1,000			

* HSA contributions are before-tax for federal income taxes and before-tax for state taxes in all states except in CA, AL, and NJ. Employer contributions made to your Health Saving Account (HSA) are required to be treated as taxable income in California and therefore will be reported as imputed income for state tax purposes. Employee contributions made to your HSA are currently required to be treated as post-tax contributions in California.

Mandatory Maintenance Prescription Mail Order Program

For Anthem Blue Cross plans, the mandatory mail order program for maintenance medications remains in effect in 2017. CVS/Caremark offers the Maintenance Choice program which allows you to fill a mandatory mail order drug at a local CVS pharmacy for the same cost as mail order. You can call CVS/Caremark Customer Service at 1-866-623-1438 with any questions you may have about their services. Please refer to the comparison charts beginning on page 18 for the cost to fill your prescription.

Access to Care Options

As a member of a LLNS Medical Plan, you have options for connecting with a doctor remotely for some common health concerns like colds, flu, fevers, and more. It's faster, easier and more convenient. ***If you experience a medical emergency, call 911 immediately.***

Kaiser: Members of Kaiser may contact their physician(s) by phone, email or video. Go to **www.kp.org/llns** for more information.

Anthem Blue Cross plans: Members of Anthem Blue Cross have access to a telemedicine option for non-emergency care via the web. Log on to **http://livehealthonline.com/** for information on registration and use of this option.

Mental Health and Substance Abuse Benefits

LLNS medical plans include mental health and substance abuse benefits as follows:

Kaiser: Kaiser members continue to access all mental health and substance abuse services through Kaiser Physicians or facilities. Refer to the medical plan comparison chart for Kaiser mental health/substance abuse coverages.

Anthem Blue Cross plans: All mental health and substance abuse services are provided by Anthem Blue Cross. To ensure full coverage of your services, contact Anthem Blue Cross for authorization of your visits. Refer to the medical plan comparison chart for Anthem Blue Cross benefit details.

Monthly Rates for 2017

Deductions are taken out of 24 bi-weekly checks. Divide by 2 to determine the per pay period deduction(s).
Employees under Davis-Bacon should divide rates by 4.

Plan	Employee Only	Employee & Adult	Employee & Child(ren)	Employee & Family
Medical				
Kaiser Permanente CA	$63.00	$132.00	$113.00	$182.00
Anthem Blue Cross EPO	$328.00	$690.00	$591.00	$953.00
Anthem Blue Cross Plus	$587.00	$1,232.00	$1,056.00	$1,701.00
Anthem Blue Cross PPO	$396.00	$832.00	$713.00	$1,149.00
Anthem Blue Cross HDHP	$169.00	$355.00	$304.00	$490.00
Anthem Blue Cross Core Value	$57.00	$118.00	$101.00	$164.00
Dental				
Delta Dental PPO (Nationwide)	Premium paid by LLNS			
Delta Care USA DMO (California residents only)	Premium paid by LLNS			
Vision				
Vision Plan	Premium paid by LLNS			
Vision Plan Plus (buy-up option)	$7.36	$14.72	$15.76	$25.20

For coverage details go to **https://benefits.llnl.gov/health-welfare/medical**

Dental Benefit Choice (LLNS Paid)

- Delta Dental PPO (nationwide)
- DeltaCare USA DMO (available only in California)

There are no dental plan design changes for 2017. A dental plan comparison spreadsheet begins on page 23.

Please note there is a difference in the networks between these two plans. The Delta Dental PPO plan allows you to see any licensed dentist; the DeltaCare USA plan limits access to DeltaCare USA network dentists only. If you have elected DeltaCare USA, make sure your dentist participates in the network by calling DeltaCare USA at 1-800-422-4234.

For coverage details go to **https://benefits.llnl.gov/health-welfare/dental**

Vision Benefit

LLNS offers a comprehensive vision care benefit provided by Vision Service Plan (VSP). There are no plan design changes for 2017 for the LLNS paid Basic plan.

Beginning in 2017, LLNS will be offering a buy-up option (Vision Plan Plus) for the vision plan. It is employee paid and provides enhanced benefits to the base plan. The base plan continues to be fully-paid by LLNS. The enhancements include:

- Frames every 12 months compared to 24 months under the base plan
- Increased frame allowance to $250 compared to $150 under the base plan
- No copay for materials
- Exam copay of $10 compared to $20 under the base plan
- Contact lens allowance of $200 compared to $130 under the base plan

A comparison of the base plan benefit and the buy-up option can be found on page 22.
To speak with VSP Member Services directly, call 1-800-877-7195.

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Note: If you choose not to purchase the buy-up option, you (and your dependents) will still be covered under the 100% LLNS paid base plan.

For coverage details go to **https://benefits.llnl.gov/health-welfare/vision**

HIPAA Special Enrollment Rights

(Health Insurance Portability and Accountability Act of 1996)

If you are declining enrollment in medical/vision/dental coverage for yourself or your eligible dependents (including your spouse, domestic partner, dependent children and domestic partner's dependent children) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in medical/vision/dental coverage if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or foster care, you may be able to enroll yourself and your dependents. Your special enrollment request must be made within 31 days after the marriage, birth, adoption, placement for adoption or foster care. Contact the Benefits Office at 925-422-9955 for more information.

LEGAL INSURANCE

Legal insurance is offered through ARAG and is **open to new enrollments** this Open Enrollment period. The legal plan will be enhanced beginning January 1, 2017 with the addition of Tax Services. The following are some of the new services included:

- Research on complex personal, non-business tax matters
- Advice regarding IRS audits and notifications
- Personal tax return preparation for $50*
- Estate planning and inheritance taxation
- Questions answered about taxes and retirement accounts and Social Security benefits

In addition, the following coverages are also offered:

- Credit Records correction – An attorney offers services for correcting inaccuracies on your credit record
- Property Tax – Assistance with disputing the tax assessment on your home
- State Tax Audit – Attorney services if you are being audited by your state taxing authority

Plan coverage continues to provide for caregiving, financial education & counseling and expanded ID theft protection—including credit monitoring, ID theft restoration & ID theft insurance.

Legal Insurance (Monthly Rate)	
Employee Only	**$12.28**
Employee & Spouse/Domestic Partner	**$16.80**
Employee & Child(ren)	**$16.80**
Employee & Family	**$18.30**

The legal insurance is open for new enrollments this Open Enrollment period.

* $50 cost for each tax preparation (federal or state). Limited to returns that include Forms 1040, 1040A or 1040EZ including Schedule A, Schedule B with 15 or fewer entries, and Schedule D with 15 or fewer entries. Returns with additional schedules or more than 15 entries on Schedule B or D will be billed at $60/hour. Other limitations and exclusions may apply.

For coverage details go to **https://benefits.llnl.gov/health-welfare/legal-insurance**.

LIFE INSURANCE

Life Insurance is offered through MetLife. Changes to Life Insurance are not limited to Open Enrollment and are not part of the Open Enrollment Self Service process. For more information see page 6, Actions Permitted Outside of Open Enrollment. **To make changes to the Life Insurance plans contact the Benefits Office at 925-422-9955.**

Basic (LLNS paid)

There are no plan design changes for Basic Life Insurance in 2017. This coverage is equal to one times your base salary up to a maximum of $400,000.

Be aware that the IRS requires the value of employer-paid life insurance in excess of $50,000 to be considered "imputed income." You have the option of waiving life insurance coverage over $50,000 at any time. You can later increase your coverage to one times your base salary.

A worksheet to calculate the amount of your taxable (imputed) income is available on the Benefits web site at **https://benefits.llnl.gov/health-welfare/life-insurance**.

Supplemental

The rates for Supplemental Life are remaining the same for 2017 and are based on your age and base salary as of each pay period. Employees enrolling in Supplemental Life during their period of initial eligibility (PIE) will be guaranteed issue up to the lesser of 3 times their base salary or $750,000.

Employees who wish to increase their life insurance coverage must complete a Statement of Health for approval by the carrier. Contact the Benefits Office with questions or if you need additional information.

Dependent

There are no plan design or rate changes for Dependent Life Insurance coverage in 2017. Employees who wish to change their dependent life insurance coverage should contact the Benefits Office to determine if a Statement of Health is required.

Life Insurance

Age	Employee Supplemental Life (rate per $1,000/month)	Dependent Basic Life (rate per $1,000/month)	Dependent Expanded Life (rate per $1,000/month)
<25	$0.022	$0.124	$0.036
25 – 29	$0.022	$0.124	$0.036
30 – 34	$0.026	$0.124	$0.045
35 – 39	$0.032	$0.220	$0.054
40 – 44	$0.051	$0.243	$0.090
45 – 49	$0.092	$0.298	$0.206
50 – 54	$0.134	$0.339	$0.288
55 – 59	$0.242	$0.339	$0.485
60 – 64	$0.378	$0.339	$0.512
65 – 69	$0.580	$0.339	$0.790
70+	$1.041	$0.339	$1.387
Child			$0.380

For coverage details go to **https://benefits.llnl.gov/health-welfare/life-insurance**

SUPPLEMENTAL DISABILITY INSURANCE

Supplemental Disability Insurance is offered through The Hartford. This insurance supplements the disability coverage available to you through California State Disability Insurance (SDI) and provides coverage to employees outside of California.

There are no plan design or rate changes for 2017. Cost for this coverage is based on your age and base salary as of each pay period. Changes to Supplemental Disability Insurance are not limited to Open Enrollment and are not part of the Open Enrollment Self Service process. **To make changes to the Supplemental Disability Insurance plan contact the Benefits Office at 925-422-9955.**

Supplemental Disability
(Multiply rate by your full time monthly salary)

Age	Waiting Period			
	7 days	30 days	90 days	180 days
<35	$0.0049	$0.0018	$0.0016	$0.0007
35 – 39	$0.0052	$0.0019	$0.0017	$0.0008
40 – 44	$0.0059	$0.0026	$0.0021	$0.0012
45 – 49	$0.0064	$0.0029	$0.0026	$0.0016
50 – 54	$0.0081	$0.0037	$0.0031	$0.0025
55 – 59	$0.0096	$0.0053	$0.0045	$0.0040
60 – 64	$0.0133	$0.0087	$0.0075	$0.0071
65 – 69	$0.0118	$0.0068	$0.0059	$0.0052
70+	$0.0089	$0.0038	$0.0032	$0.0021

For coverage details go to **https://benefits.llnl.gov/health-welfare/disability**

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) allow you to put money aside on a before-tax basis—the Health Care Reimbursement Account (HCRA) for eligible health care expenses and the Dependent Care Reimbursement Account (DCRA) for eligible dependent day care expenses. Contributions are deducted from your paycheck on a pretax (tax-free) basis—before federal, state, and Social Security (FICA) taxes are taken out. Because your Social Security benefits are based on earnings, your participation in the FSA may reduce this benefit, depending on the amount you earn.

Any expenses for reimbursement with 2017 contributions must be incurred in that year. Paper claims for eligible expenses incurred January 1 − December 31, 2017 must be submitted for reimbursement by March 31, 2018.

If you want to make FSA contributions in 2017, you must enroll during Open Enrollment, even if you are contributing in 2016. After Open Enrollment, you cannot make changes to your contributions except under certain limited situations. For information about permissible election changes go to https://benefits.llnl.gov/health-welfare/summary-plan and see the LLNS Health and Welfare Benefit Plan for Employees Summary Plan Description (SPD), Section 7, “Making Changes to Your Elections.” For specific questions regarding eligible FSA expenses, visit the ADP web site at **www.spendingaccounts.info** or see IRS Publications 502 and 503.

The access code for first time registrants on ADP’s web site is **LAWRENCEL-89503**.

For coverage details go to **https://benefits.llnl.gov/health-welfare/flexible-spending**

Health Care Reimbursement Account (HCRA)

The HCRA limit remains at $2,550 for 2017. HCRA allows you to set aside earnings on a before-tax basis to pay for eligible out-of-pocket health care expenses you and your eligible dependents incur in 2017. The amount you contribute to your account will reduce your taxable income.

Examples of eligible health care expenses are:

- Deductibles, co-payments, and co-insurance amounts not paid by your medical, prescription, dental, or vision plans
- Over-the-counter drugs, if prescribed by a doctor, that are taken to alleviate or treat an injury or sickness
- Acupuncture not covered by your medical plan
- Orthodontia not covered by the dental plan
- Hearing aids

You and your dependents can pay for purchases directly from your HCRA account using a special debit card, reducing the number of claims you need to submit. The HCRA debit card works like a credit card, only funds are deducted from your HCRA account balance. If you are a new participant to the program for 2017, you will automatically receive a card when you enroll. If you have participated in 2016, keep your card as your 2017 annual election amount will be funded and added to the card effective January 1, 2017.

Remember that you forfeit any money you don't use so calculate your contributions carefully.

A calculator is available at **www.spendingaccounts.info**

Paper claims for eligible expenses incurred January 1 – December 31, 2017 must be submitted for reimbursement by March 31, 2018.

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Keep your receipts for services paid with the ADP card as you may be asked to substantiate the expense to ensure it meets IRS requirements as an eligible item.

Dependent Care Reimbursement Account (DCRA)

DCRA allows you to set aside money on a before-tax basis to pay for dependent day care expenses incurred in 2017, due to your or your spouse's employment or student status. The maximum amount you can contribute is $5,000 per year (per family) if you're filing with the IRS as married filing jointly or as head of household, or $2,500 per year if you're filing as married filing separately. This plan may be used for dependent day care expenses for children under age 13 or for disabled family members who qualify under IRS rules. The care provider must have a federal taxpayer identification or U.S. Social Security number. The amount you contribute to your spending account will reduce your taxable income. You are reimbursed by submitting receipts for eligible expenses to ADP with a reimbursement form available at **www.spendingaccounts.info**.

Remember that you forfeit any money you don't use so calculate your contributions carefully.
Claims for eligible expenses incurred January 1 – December 31, 2017 must be submitted for reimbursement by March 31,

Depending on your personal income tax situation, you may get a greater tax savings with the Child Care Tax Credit than with DCRA. You may want to ask a tax advisor which alternative is best for you.

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE (AD&D)

There are no AD&D plan design or rate changes in 2017. AD&D insurance protects you and your family from the unforeseen financial hardship of an accident that causes death, dismemberment, or loss of sight, speech, or hearing. The plan provides worldwide coverage for you and your enrolled family members. For coverage details go to **https://benefits.llnl.gov/health-welfare/life-insurance**.

Changes to AD&D Insurance are not limited to Open Enrollment and are not part of the Open Enrollment Self Service process. **To make changes to AD&D coverage contact the Benefits Office at 925-422-9955.**

Accidental Death & Dismemberment Insurance (AD&D)
Monthly Rate

Coverage	Plan Options		
	Self	Family (You, spouse /partner, and eligible children)	Modified Family (You and eligible children)
$10,000	$0.20	$0.35	$0.25
$20,000	$0.40	$0.70	$0.50
$30,000	$0.60	$1.05	$0.75
$40,000	$0.80	$1.40	$1.00
$50,000	$1.00	$1.75	$1.25
$60,000	$1.20	$2.10	$1.50
$70,000	$1.40	$2.45	$1.75
$80,000	$1.60	$2.80	$2.00
$90,000	$1.80	$3.15	$2.25
$100,000	$2.00	$3.50	$2.50
$125,000	$2.50	$4.38	$3.13
$150,000	$3.00	$5.25	$3.75
$175,000	$3.50	$6.13	$4.38
$200,000	$4.00	$7.00	$5.00
$300,000	$6.00	$10.50	$7.50
$400,000	$8.00	$14.00	$10.00
$500,000	$10.00	$17.50	$12.50

BUSINESS TRAVEL ACCIDENT INSURANCE (LLNS PAID)

There are no plan design changes to the Business Travel Accident benefit for 2017. Business Travel Accident insurance covers accidental death or dismemberment of Lab employees traveling on official LLNS business or while engaged in designated hazardous activities on behalf of LLNS.

If you are eligible, you will be covered 24 hours/day, worldwide, up to $100,000. This coverage is in addition to other insurance you may have at the time of the accident. For coverage details go to **https://benefits.llnl.gov/health-welfare/life-insurance**.

BENEFICIARIES

Open Enrollment is a good time to review your beneficiary designations. You may change your designated beneficiary at any time on LAPIS for Basic Life, Supplemental Life, AD&D, Business Travel Accident, and the Pension Plan (TCP1) Single Sum Death Benefit. Go to "Insurance Summary" from the LAPIS home page and click on the benefit to edit your beneficiaries. Once your new designations are processed, all previous designations are invalid. **For questions, please contact the Benefits Office at 925-422-9955.**

To designate a beneficiary for the LLNS 401(k) plan call Fidelity Investments at 1-800-835-5095 or visit their website at **www.netbenefits.com**.

REQUIRED NOTICES

Notice of Availability of Notice of Privacy Practices
The LLNS Health and Welfare Benefit Plan for Employees (the "Plan") provides health benefits to eligible employees of Lawrence Livermore National Security, LLC (the "Company") and their eligible dependents as described in the Summary Plan Document for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits. The Plan is required by law to provide notice to participants of the Plan's duties and privacy practices with respect to covered individuals' protected health information ("PHI"), and has done so by providing to Plan participants a notice of privacy practices, which describes the ways that the Plan uses and discloses PHI. To receive a copy of the Plan's notice of privacy practices, you can go to the LLNS Benefits web site **https://benefits.llnl.gov/** or contact the Benefits Office at 925-422-9955.

The Women's Health and Cancer Rights Act of 1998
The Women's Health and Cancer Rights Act of 1998 requires that if a group health plan provides medical and surgical benefits for mastectomies, it must also provide coverage for reconstructive surgery and prostheses following mastectomies.

The law mandates that a participant or beneficiary who is receiving benefits under the plan for a covered mastectomy, and who elects breast reconstruction in connection with the mastectomy, will also receive coverage for:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce asymmetrical appearance.
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same annual deductible, co-insurance and/or co-payment provisions otherwise applicable under the plans.

Important Notice from LLNS about Your Prescription Drug Coverage and Medicare
Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with LLNS and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. LLNS has determined that the prescription drug coverage offered by the LLNS Health and Welfare Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage. Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan. In addition, if you lose or decide to leave employer sponsored coverage, you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

If you do decide to join a Medicare prescription drug plan and drop your LLNS medical coverage (which includes prescription drug coverage), be aware that you and your dependents may not be able to get this coverage back until the calendar year after the following Open Enrollment period. Remember, your current LLNS medical coverage pays for other health expenses, in addition to prescription drugs. Contact the LLNS Benefits Office by telephone at 925-422-9955 or by mail at Lawrence Livermore National Security, LLC, Benefits Office, 7000 East Avenue, L-640, Livermore, CA 94550 for more information about what happens to your coverage if you join a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with LLNS and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 consecutive days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium may go up at least 1% of

the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage:

Contact the LLNS Benefits Office by telephone at 925-422-9955 or by mail at Lawrence Livermore National Security, LLC, Benefits Office, 7000 East Avenue, L-640, Livermore, CA 94550 for further information. NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through LLNS changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help visit Social Security on the web at **www.socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Patient Protection Disclosure Notice

Kaiser Permanente generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in their network and who is available to accept you or your family members. Until you make this designation, Kaiser Permanente designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser at **www.kp.org/llns** or 1-800-464-4000. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Kaiser Permanente or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in Kaiser's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Kaiser at **www.kp.org/llns** or 1-800-464-4000.

The Anthem Blue Cross medical options do not require the designation of a primary care provider.

RESOURCES

MyLLNL front page, click on the “Open Enrollment” link for Open Enrollment materials, details on plan rates, web site links, the imputed income calculation worksheet, and much more. This site will be updated periodically as materials become available.

Go to LAPIS Self Service to review your current enrollments and to make Open Enrollment elections.

Carrier/Plan	URL	Telephone #	California Group #s
Kaiser Permanente CA	http://my.kp.org/llns	1-800-464-4000	N. Cal: 602567 S. Cal: 299065
Anthem Blue Cross EPO	www.anthem.com/ca/llns/	1-866-641-1689	175203E001
Anthem Blue Cross Plus	www.anthem.com/ca/llns/	1-866-641-1689	175203P001
Anthem Blue Cross PPO	www.anthem.com/ca/llns/	1-866-641-1689	175203P051
Anthem Blue Cross Core	www.anthem.com/ca/llns/	1-866-641-1689	175203C001
Anthem Blue Cross HDHP	www.anthem.com/ca/llns/	1-866-641-1689	175203P059
CVS/Caremark	www.caremark.com	1-866-623-1438	
Delta Dental PPO	www.deltadentalins.com/llns	1-800-777-5854	3221-0011
Delta Care USA DMO	www.deltadentalins.com/llns	1-800-422-4234	5980
Vision Service Plan (VSP)	www.vsp.com/	1-800-877-7195	12-316390
ADP	http://www.spendingaccounts.info/	1-866-334-4664	
ARAG Legal	http://members.ARAGgroup.com/LLNS	1-800-247-4184	

For additional resources, please visit us at: **https://benefits.llnl.gov/resources/contact-us**

2017 Medical Plan Options Comparison of Benefit Coverages

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser
Member services	1-866-641-1689	1-866-641-1689	1-866-641-1689	1-866-641-1689	1-866-641-1689	1-800-464-4000
Web site	www.anthem.com/ca/llns/	www.anthem.com/ca/llns/	www.anthem.com/ca/llns/	www.anthem.com/ca/llns/	www.anthem.com/ca/llns/	www.my,kp.org/llns
HSA Funding	N/A	N/A	$750 Individual; $1,500 Family	N/A	$750 Individual; $1,500 Family	N/A
Annual deductible: Individual/Family	In Network - $300 Individual; $900 Family	In Network - $500 Individual; $1,500 Family	$3,000 Individual; $6,000 Family; combined in/out-of-network; no coverage paid for any member of a family unless $3,000 deductible is met	$0 Individual; $0 Family	In Network - $1,500 Individual; $3,000 Family; no coverage paid for any member of a family unless $3,000 deductible is met	$0 Individual; $0 Family
	Out of Network - $500 Individual; $1,500 Family	Out of Network - $1,000 Individual; $3,000 Family		No coverage Out-of-Network	Out of Network - $3,000 Individual; $6,000 Family; no coverage for any member of a family unless $6,000 deductible is met	No coverage Out-of-Network
Coinsurance percentage	In Network - 80% covered until out-of-pocket maximum is met	In Network - 80% covered until out-of-pocket maximum is met	In Network - 80% covered until out-of-pocket maximum is met	90% covered	In Network - 90% covered until out-of-pocket maximum is met	100% covered
	Out of Network - 60% covered until out-of-pocket maximum is met; subject to Maximum Allowed Amount	Out of Network - 60% covered until out-of-pocket maximum is met; subject to Maximum Allowed Amount	Out of Network - 60% covered until out-of-pocket maximum is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - 70% covered until out-of-pocket maximum is met; subject to Maximum Allowed Amount	No coverage Out-of-Network
Out-of-pocket maximum: Individual/ Family	In Network - $2,500 Individual; $7,500 Family; in & out-of-network maximums are exclusive of each other; includes deductible and copays	In Network - $3,000 Individual; $9,000 Family; in & out-of-network maximums are exclusive of each other; includes deductible	In Network - $5,000 Individual; $10,000 Family; in & out-of-network maximums are exclusive of each other; includes deductible and Rx maximum allowed amount	$1,000 Individual; $3,000 Family; includes copays	In Network - $3,000 Individual; $6,000 Family; in & out-of-network maximums are exclusive of each other; includes deductible and Rx maximum allowed amount	$1,500 Individual; $3,000 Family; copays included; excluding durable medical equipment, prescription drugs and infertility services
	Out of Network - $7,000 Individual; $21,000 Family; in & out-of-network maximums are exclusive of each other; includes deductible and copays	Out of Network - $6,000 Individual; $18,000 Family; in & out-of-network maximums are exclusive of each other; includes deductible	Out of Network - $10,000 Individual; $20,000 Family; in & out-of-network maximums are exclusive of each other; includes deductible and Rx maximum allowed amount	No coverage Out-of-Network	Out of Network - $6,000 Individual; $12,000 Family; in & out-of-network maximums are exclusive of each other; includes deductible and Rx maximum allowed amount	No coverage Out-of-Network
Ability to self-refer to specialists	Yes	Yes	Yes	Yes	Yes	Check with your guidebook to see if your facility has departments that don't require a referral
				No coverage Out-of-Network		No coverage Out-of-Network
Primary doctor office visit	In Network - $25 copay	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	$25 copay	In Network - 90% covered after deductible is met	$25 copay
	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network
Specialist office visit	In Network - $35 copay	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	$35 copay	In Network - 90% covered after deductible is met	$25 copay
	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network
Preventive care	In Network - 100% covered	In Network - 100% covered	In Network - 100% covered	100% covered	In Network - 100% covered	100% covered; for preventive
	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network
Mammogram	In Network - Diagnostic: 80% covered after deductible is met; 100% covered for preventive care	In Network - Diagnostic: 80% covered after deductible is met; 100% covered for preventive care	In Network - Diagnostic: 80% covered after deductible is met; 100% covered for preventive care	Diagnostic: 90% covered; 100% covered for preventive care	In Network - Diagnostic: 90% covered after deductible is met; 100% covered for preventive care	100% covered for preventive care
	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network

NOTE: If there is a discrepancy between the benefits as described in this chart and the plan administraor's system, the plan administratior's system governs for determining benefit coverage.

2017 Medical Plan Options Comparison of Benefit Coverages

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser
Immunizations (child)	In Network - 100% covered for preventive care	In Network - 100% covered for preventive care	In Network - 100% covered for preventive care	100% covered for preventive care	In Network - 100% covered for preventive care	100% covered for preventive care
	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network
Allergy tests and treatments	In Network - Diagnostic test/diagnostic treatment: $25 copay PCP, $35 copay Specialist; allergy injections 100% covered	In Network - Diagnostic test/diagnostic treatment: 80% covered after deductible is met; allergy injections 100% covered	In Network - Diagnostic test/diagnostic treatment: 80% covered after deductible is met	Diagnostic test/diagnostic treatment: $25 copay PCP, $35 copay Specialist; allergy injections 100% covered	In Network - Diagnostic test/diagnostic treatment: 90% covered after deductible is met	Diagnostic and testing: $25 copay per visit, allergy injections: $5 copay per visit
	Out of Network - Diagnostic test/diagnostic treatment: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - Diagnostic test/diagnostic treatment: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - Diagnostic test/diagnostic treatment: 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - Diagnostic test/diagnostic treatment: 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network
Outpatient surgery	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	90% covered	In Network - 90% covered after deductible is met	$100 copay; per procedure
	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount; benefit limited to $350/visit	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network
Outpatient physical, speech and occupational therapy	In Network - $25 copay; limited to 60 visits per year combined physical, speech and occupational therapy, in-network and out-of-network	In Network - 80% covered after deductible is met; limited to limited to 60 visits per year combined physical, speech and occupational therapy, in-network and out-of-network	In Network - 80% covered after deductible is met; limited to 60 visits per year combined physical, speech and occupational therapy, in-network and out-of-network	$25 copay; limited to 60 visits per year combined physical, speech and occupational therapy	In Network - 90% covered after deductible is met; limited to 60 visits per year combined physical, speech and occupational therapy, in-network and out-of-network	$25 copay; per visit
	Out of Network - 60% covered after deductible is met; limited to 60 visits per year combined physical, speech and occupational therapy, in-network and out-of-network; subject to Maximum Allowed Amount limits	Out of Network - 60% covered after deductible is met; limited to 60 visits per year combined physical, speech and occupational therapy, in-network and out-of-network; subject to Maximum Allowed Amount limits	Out of Network - 60% covered after deductible is met; limited to 60 visits per year combined physical, speech and occupational therapy, in-network and out-of-network; subject to Maximum Allowed Amount limits; benefit limited to $25 per visit	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; limited to 60 visits per year combined physical, speech and occupational therapy, in-network and out-of-network; subject to Maximum Allowed Amount limits	No coverage Out-of-Network
Fertility services (excludes in vitro fertilization)	In Network only - 50% covered after deductible is met; $20,000 lifetime maximum for all infertility benefits combined; medical and pharmacy	Not covered	Not covered	In Network only - 50% covered; $20,000 lifetime maximum for all infertility benefits combined; medical and pharmacy	Not covered	Covered at 50% member rate; for diagnosis and treatment of involuntary infertility when approved by a Plan physician
In-patient hospital services (including physician, surgeon, lab and x-ray)	In Network - $250 copay per admission; then 80% covered after deductible is met; $200 penalty if nonemergency services are not preauthorized	In Network - 80% covered after deductible is met; $200 penalty if nonemergency services are not preauthorized	In Network - 80% covered after deductible is met	$250 copay per admission; then 90% covered; $200 penalty if nonemergency services are not preauthorized	In Network - 90% covered after deductible is met	$500 copay per admission
	Out of Network - 60% covered after deductible is met; $200 penalty if nonemergency services are not preauthorized; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; $200 penalty if nonemergency services are not preauthorized; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network
Emergency room (not followed by admission)	In Network - $100 copay; then 80% covered after deductible is met; copay waived if admitted	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	In-Network: $100 copay; then 90% covered after deductible is met; copay waived if admitted	In Network - 90% covered after deductible is met	$100 copay; waived if admitted
	Out of Network - $100 copay then 80% covered after deductible is met; copay waived if admitted	Out of Network - 80% covered after deductible is met	Out of Network - 80% covered after deductible is met; non-emergencies subject to Maximum Allowed Amount	Out-of-Network: $100 copay for emergencies then 90% covered after deductible is met; copay waived if admitted	Out of Network - 90% covered after deductible is met	$100 copay; waived if admitted

NOTE: If there is a discrepancy between the benefits as described in this chart and the plan administraor's system, the plan administratior's system governs for determining benefit coverage.

2017 Medical Plan Options Comparison of Benefit Coverages

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser
Urgent care clinic visit	In Network - $25 copay	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	$25 copay	In Network - 90% covered after deductible is met	$25 copay; per visit
	Out of Network - 60% covered; after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	$25 copay; per visit; non-Plan providers covered when outside the service area
Ambulance services	In Network - 80% covered after deductible is met; must be medically necessary	In Network - 80% covered after deductible is met; must be medically necessary	In Network - 80% covered after deductible is met; must be medically necessary	In Network - 90% covered; must be medically necessary	In Network - 90% covered after deductible is met; must be medically necessary	$50 copay per trip
	Out of Network - 60% covered after deductible is met; no copay if true emergency; must be medically necessary; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; must be medically necessary; subject to Maximum Allowed Amount	Out of Network - 80% covered after deductible is met; must be medically necessary; subject to Maximum Allowed Amount	Out of Network - 90% covered; must be medically necessary; subject to Maximum Allowed Amount	Out of Network - 70% covered after deductible is met; must be medically necessary; subject to Maximum Allowed Amount	
Mental Health: Outpatient coverage	In-network: $0 copay for visits 1-5; $25 copay for visits 6 and over	In-network: 80% covered after deductible is met	In-network: 80% covered after deductible is met	In-network: $0 copay for visits 1-5; $25 copay for visits 6 and over	In-network: 90% covered after deductible is met	$25 copay individual visit; $12 copay group visit; unlimited visits
	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out-of-network: 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network
Mental Health: Inpatient coverage	In-network: 80% covered after deductible is met	In-network: 80% covered after deductible is met	In-network: 80% covered after deductible is met	In-network: 90% covered	In-network: 90% covered after deductible is met	$500 copay per admission
	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out-of-network: 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network
Substance Abuse: Outpatient coverage	In-network: $0 copay for visits 1-5; $25 copay for visits 6 and over	In-network: 80% covered after deductible is met	In-network: 80% covered after deductible is met	In-network: $0 copay for visits 1-5; $25 copay for visits 6 and over	In-network: 90% covered after deductible is met	$25 copay individual visit; $5 copay group visit; unlimited visits
	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out-of-network: 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network
Substance Abuse: Inpatient coverage	In-network: 80% covered after deductible is met	In-network: 80% covered after deductible is met	In-network: 80% covered after deductible is met	In-network: 90% covered	In-network: 90% covered after deductible is met	$500 copay per admission; $100 copay for transitional residential recovery services; mental health/chemical dependency services accrue to out-of-pocket maximum
	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out-of-network: 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network
Chiropractic/ Accupuncture	In Network - $25 copay; limited to 25 visits per calendar year	In Network - 80% covered after deductible is met; limited to 25 visits per calendar year	In Network - 80% covered after deductible is met; limited to 25 visits per year; combined in-network and out-of-network	$25 copay; limited to 25 visits per calendar year	In Network - 90% covered after deductible is met; limited to 25 visits per calendar year	Member discounts available through American Specialty Health network
	Out of Network - 60% covered after deductible is met; limited to 25 visits per calendar year; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; limited to 25 visits per calendar year; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; limited to 25 visits per calendar year; combined in-network and out-of-network; subject to Maximum Allowed Amount; benefit limited to $25 per visit	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; limited to 25 visits per calendar year; subject to Maximum Allowed Amount	No coverage Out-of-Network
Prescription drug vendor	Caremark	Caremark	Caremark	Caremark	Caremark	Kaiser
Prescription drug member services	1-866-623-1438	1-866-623-1438	1-866-623-1438	1-866-623-1438	1-866-623-1438	1-800-464-4000

NOTE: If there is a discrepancy between the benefits as described in this chart and the plan administraor's system, the plan administratior's system governs for determining benefit coverage.

2017 Medical Plan Options Comparison of Benefit Coverages

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser
Prescription drug Web site	www.caremark.com	www.caremark.com	www.caremark.com	www.caremark.com	www.caremark.com	www.kp.org/llns
Annual prescription deductible	Not applicable	Not applicable	Medical deductible applies; member pays 100% of the Rx cost until medical deductible is met	Not applicable	Medical deductible applies; member pays 100% of the Rx cost until medical deductible is met	Not applicable
Prescription benefits are covered under medical deductible	No	No	Yes	No	Yes	Not applicable
Annual Rx Out-of-pocket maximum	$2,800 Individual; $5,700 Family (in-network only)	$2,100 Individual; $4,200 Family (in-network only)	Medical out-of-pocket maximum applies; once medical out-of-pocket maximum is met, Rx is 100% covered for the remainder of the calendar year	$3,500 Individual; $7,000 Family	Medical out-of-pocket maximum applies; once medical deductible is met, Rx is 100% covered for the remainder of the calendar year	Not applicable
Retail generic	In Network - $10 copay; 30 day supply Out of Network - 50% of average whole price schedule plus charges above the schedule	In Network - $10 copay; 30 day supply Out of Network - 50% of average whole price schedule plus charges above the schedule	In Network - 80% covered after deductible is met Out of Network - 60% covered after deductible is met	$10 copay; 30 day supply; Non-participating pharmacies: 50% of average whole price schedule plus charges above the schedule	In Network - 90% covered after deductible is met Out of Network - 70% covered after deductible is met	$10 for up to a 30-day supply; $30 for up to a 100-day supply; at Kaiser Pharmacy; as prescribed by Plan Physician
Retail formulary brand	In Network - 80% covered; $40 minimum copay, $60 maximum copay; 30 day supply Out of Network - 50% of average whole price schedule plus charges above the schedule	In Network - 80% covered; $40 minimum copay, $60 maximum copay; 30 day supply Out of Network - 50% of average whole price schedule plus charges above the schedule	In Network - 80% covered after deductible is met Out of Network - 60% covered after deductible is met	80% covered; $40 minimum copay, $60 maximum copay; 30 day supply; Non-participating pharmacies: 50% of average whole price schedule plus charges above the schedule	In Network - 90% covered after deductible is met Out of Network - 70% covered after deductible is met	$35 for up to a 30-day supply; $105 for up to a 100-day supply; at Kaiser Pharmacy; as prescribed by Plan Physician
Retail nonformulary brand	In Network - 60% covered; $60 minimum copay, $100 maximum copay; 30 day supply Out of Network - 50% of average whole price schedule plus charges above the schedule	In Network - 60% covered; $60 minimum copay, $100 maximum copay; 30 day supply Out of Network - 50% of average whole price schedule plus charges above the schedule	In Network - 80% covered after deductible is met Out of Network - 60% covered after deductible is met	60% covered; $60 minimum copay, $100 maximum copay; 30 day supply; Non-participating pharmacies: 50% of average whole price schedule plus charges above the schedule	In Network - 90% covered after deductible is met Out of Network - 70% covered after deductible is met	$35 for up to a 30-day supply; $105 for up to a 100-day supply; at Kaiser Pharmacy; as prescribed by Plan Physician
Mail order generic	$20 copay; 90 day supply; must use plan mail order facility	$20 copay; 90 day supply; must use plan mail order facility	80% covered after deductible is met	$20 copay; 90 day supply; must use plan mail order facility	90% covered after deductible is met	$10 for up to a 30-day supply; $20 for up to a 100-day supply; mail order as prescribed by Plan Physician
Mail order formulary brand	80% covered; $80 minimum copay, $120 maximum copay; 90 day supply; must use plan mail order facility	80% covered; $80 minimum copay, $120 maximum copay; 90 day supply; must use plan mail order facility	80% covered after deductible is met	80% covered; $80 minimum copay, $120 maximum copay; 90 day supply; must use plan mail order facility	90% covered after deductible is met	$35 for up to a 30-day supply; $70 for up to a 100-day supply; mail order as prescribed by Plan Physician
Mail order nonformulary brand	60% covered; $120 minimum copay, $200 maximum copay; 90 day supply; must use plan mail order facility	60% covered; $120 minimum copay, $200 maximum copay; 90 day supply; must use plan mail order facility	80% covered after deductible is met	60% covered; $120 minimum copay, $200 maximum copay; 90 day supply; must use plan mail order facility	90% covered after deductible is met	$35 for up to a 30-day supply; $70 for up to a 100-day supply; mail order as prescribed by Plan Physician and deemed medically necessary

NOTE: If there is a discrepancy between the benefits as described in this chart and the plan administraor's system, the plan administratior's system governs for determining benefit coverage.

2017 Vision Plan Comparison of Benefit Coverages

	Vision Plan (LLNS paid)	Vision Plan Plus (Buy-up option, employee paid)
Frequency (Exam/Lenses/Frame)	12/12/24 (January/January/Every other January)	12/12/12 (January/January/January)
Copay	$20 exam/$20 materials	$10 exam
Examination	Covered after copay	Covered after copay
Lenses	Covered after copay	Covered after copay
Lens Options:		
Anti-reflective coating	$37-75 copay	$37-75 copay
UV Protection	$10-14 copay	$10-14 copay
Frame allowance	$150	$250
Frame allowance @ Costco	$80	$135
Elective contact lenses	$130	$200
Necessary contact lenses	Covered after copay	Covered after copay
Employee cost (monthly)	$0	$7.36/$14.72/$15.76/$25.20 (see page 8)

2017 Dental Plan Option Comparison of Benefit Coverages

	Delta Dental PPO	DeltaCare DHMO (available in CA only)
Member services	1-800-777-5854	1-800-422-4234
Web site	deltadentalins.com/llns	deltadentalins.com/llns
Network	Any licensed dentist; Delta Dental PPO dentist provides higher benefit level	DeltaCare USA network of dentists
Annual deductible: Individual/Family	In Network - $50 Individual; combined for both basic and major dentistry; waived for preventive/diagnostic care	$0 Individual; $0 Family
	Out of Network - $50 Individual; combined for both basic and major dentistry; waived for preventive/ diagnostic care	Not applicable
Annual maximum coverage per person	Delta Dental PPO Dentist - $1,700	Not applicable
	Non Delta Dental PPO Dentist - $1,500	Not applicable
Preventive care benefits	In Network - 100% covered; sealants 80% covered	$0-$45 copays
	Out of Network - 100% covered; sealants 75% covered	Not Applicable
Annual service limits-- preventive care	In Network Cleaning: 2 per calendar year* Exams: 2 exams of any type per calendar year * 3rd cleaning per calendar year provided for pregnant women	Cleaning and fluoride, one per 6 month period, child to age 19.
	Out of Network - same as in network	Not Applicable
Basic services (including fillings, routine extractions, endodontics, periodontics)	In Network - 80% covered after deductible is met	100% covered; for standard benefit; copay for endodontics, periodontics
	Out of Network - 75% covered after deductible is met	Not Applicable
Major services (including crowns, bridges, implants, dentures)	In Network - 50% covered after deductible is met	Copay applies
	Out of Network - 50% covered after deductible is met	Not Applicable
Orthodontia benefits	In Network - 50% covered	$1,700 - Child; $1,900 Adult; $100 Start Up Fee
	Out of Network - 50% covered	Not Applicable
Service limits and maximums-- orthodontia	In Network - Limited to $1,500 per lifetime for dependent children; $500 per lifetime for adults	Check with Plan
	Out of Network - Limited to $1,500 per lifetime for dependent children; $500 per lifetime for adults	Not Applicable

Open Enrollment Dates and Events

Date	Activity
Wednesday, October 19 **12:00PM - 4:00PM** Spouses are welcome to attend (badging required)	**Benefits Fair** Building 543 Atrium
Wednesday, October 19 **11:00AM to 12:00PM and** **2:00PM to 3:00PM**	**Brown Bag Meetings** Building 543 Auditorium
Thursday, October 20 **1:30PM to 2:30PM**	**Brown Bag Meeting** Site 300, B871 - Room 148 (Fiddleneck Room)

Communications will appear regulary in Newsline and on the Benefits website:
https://benefits.llnl.gov

Open Enrollment transactions must be made before 5:00PM (PT) on Friday, November 11, 2016

Benefits changes made during Open Enrollment become effective January 1, 2017 and will appear on your first paycheck in January.