2023

OPEN ENROLLMENT

LAWRENCE LIVERMORE NATIONAL LABORATORY

OCTOBER 24 - NOVEMBER 11, 2022 (EMPYREAN)
OCTOBER 15 - DECEMBER 7, 2022 (VIA BENEFITS)

RETIREE GUIDE

Benefits

notice

If you are enrolled in Medicare or will become eligible to enroll in Medicare during 2023, a Federal law gives you more choices about your prescription drug coverage. Please see page 14 for more details.

ATTENTION:
MEDICARE-ELIGIBLE RETIREES

Tips to help you through Open Enrollment

Review materials received to understand your options:

- LLNS - 2023 Retiree Open Enrollment guide and materials
- Empyrean - Personal Enrollment Worksheet
- Via Benefits - Fall Newsletter and HRA Reminder Letter
- Medicare - Medicare & You 2023

Determine if you need to make a change. Reasons to change your benefits?

- You want to enroll in the Vision Choice plan
- Your plan has been canceled
- You have a significant increase in premiums
- You have a change in medication and/or medication-related charges
- Your doctor or hospital is no longer in your plan's network
- You've moved

Contact Via Benefits at **(866) 682-4841** or Empyrean at **(844) 750-5567** to make changes.

Elect your Medicare Supplement through Via Benefits or Kaiser Permanente Senior Advantage in California through Empyrean to be eligible for the HRA. Do not elect a plan through an independent broker or directly through the plan or you may lose your HRA funding.

When calling Via Benefits

- Enter your information when prompted. This will bring up your information to the representative and reduce repeating your information.
- Schedule an appointment–appointments are given on a first come, first served but new appointments are added as new advisors are made available. Appointment availability is spread throughout the enrollment period.
- Expect to be on hold when calling during your scheduled appointment time. Your advisor may be ending a call with the previous retiree. Appointment times are estimates.

NOTE: The best time to call is in the afternoon or later in the week. Monday/Tuesday mornings are very busy.

About Empyrean

If you made arrangements to have HRA payments made directly to Empyrean they will automatically continue in 2023. If you would like to opt out of HRA payments being made directly to Empyrean please contact the Kaiser HRA payment Center at **(877) 761-3399.** If you do not want to make any changes to your current plan elections, they will continue into 2023 unless you have been notified otherwise.

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2023

Retiree Guide

Lawrence Livermore National Laboratory

INTRODUCTION

It's Open Enrollment season again—the time of year to review your health and welfare benefits and make changes, if you choose to. LLNS provides you with this guide as an overview of what you can expect this Open Enrollment.

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 2023 Open Enrollment Guide is a Summary of Material Modifications to the LLNS Health and Welfare Benefit Plan for Retirees (October 2017). 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.

This guide is structured in five sections

Information that applies to:

1. All retirees and eligible dependents
2. Those not eligible for Medicare
3. Medicare eligible—currently in Kaiser
4. Medicare eligible—not currently in Kaiser
5. Plan Comparison Charts (medical, dental and vision)

This year Empyrean will conduct a virtual Open Enrollment presentation that will be held on Wednesday, October 19, 2022 from 9:00 a.m. to 10:00 a.m. Pacific Time.

For details go to

https://goempyrean.zoom.us/j/98364803252?pwd=Q01HZjVYakZ6L2RJNjFyRnVlaitVUT09

and log in for this event. In addition to this guide, you will also receive information from Empyrean on your current coverages and options available for 2023. If you are eligible for Medicare, you will also receive information from Via Benefits.

We encourage you to carefully review the information in this guide, as well as any information you receive from Empyrean and/or Via Benefits. Consider whether you are enrolled in plans that are right for you and your eligible family members and follow the instructions provided in the information you receive.

If you do not want to make any changes to your current medical, dental, vision or legal plan elections, no action is required. If you want to enroll in the vision choice plan see page 37 for more details.

Have you Moved?

If you have a change of address, please contact Empyrean's Customer Care Center at **(844) 750-5567**, in addition to notifying your pension administrator.

ALL RETIREES & ELIGIBLE DEPENDENTS

Actions You Can Take During Open Enrollment:

Open Enrollment is the only time during the calendar year when you can make changes to your medical, dental, legal or vision coverage unless you experience a Qualifying Life Event.

- Enroll in a different medical plan.
- Enroll in the dental, legal, or vision plan.
- Change to a different dental plan. (California residents only)
- Change Vision Plans
- Suspend your medical and/or dental plan; or enroll in a plan if you previously suspended coverage.
- Enroll eligible family members in your medical, dental, vision and legal plans.
- Cancel health plan coverage for currently enrolled family members.

If no changes are made during Open Enrollment you will remain in the same plans. If you are enrolled in a medical plan through Via Benefits, be sure to refer to the information on page 25.

Open Enrollment changes go into effect on January 1, 2023.

NOTE: If you are covering a dependent child whose eligibility requires tax dependency and tax dependency is lost at any time, promptly notify Empyrean at (844) 750-5567.

Actions Permitted Outside of Open Enrollment

(Qualifying Life Event)

You can 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 due to and correspond with the event. Medical, dental, legal and vision 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 or registered domestic partnership, including marriage, divorce, death of your spouse or registered domestic partner, legal separation, or annulment;
- A change in the number of your tax dependents including through birth, adoption, placement for adoption, or death;
- A change in employment status by you, your spouse, registered domestic partner, or dependent that results in gaining or losing eligibility for coverage;
- Your dependent's ability or inability to satisfy dependent eligibility requirements;
- A change in residence by you, your spouse or registered domestic partner, or dependent that causes you to lose access to providers in your plan's network.

For more information see the LLNS Health and Welfare Benefit Plan for Retirees Summary Plan Description (October 2017) located at https://www.llnl.gov/sites/www/files/2021-06/LLNS-Retirees-SPD.pdf

NOTE: If you do not notify Empyrean within 31 days of the event, you will **not** be able to add a dependent or make any other changes until the next Open Enrollment period, with benefit coverage effective the following January 1, 2024.

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 related to the enrollment of ineligible family members and you could be subject to costs 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 Retirees Summary Plan Description (October 2017). Questions about eligibility should be directed to Empyrean's Customer Care Center at **(844) 750-5567**.

If you and your spouse or registered domestic partner are both LLNS employees/retirees, one of you may cover the other as a dependent, or each of you may have separate coverage. However, only one of you may cover each of your children or the children of a registered domestic partner as dependents. You may change who covers them during the open enrollment period.

Dental Benefit Choices

- Delta Dental PPO (Nationwide)
- DeltaCare USA DMO (Available in California only)

There are no dental plan design changes for 2023. A dental plan comparison spreadsheet is on page 36. Plan coverage details for 2023 are available by contacting Empyrean's Customer Care Center **(844) 750-5567** or at www.llnsretireebenefits.com. 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. If you have elected DeltaCare USA, make sure your dentist participates in the network and accepts new patients by calling DeltaCare USA at **(800) 422-4234**.

Legal Insurance

MetLife Legal Plan is the country's largest provider of group legal benefits. The plan covers members, their spouses, and dependents and gives them access to more than 18,000 attorneys who can provide legal consultation and representation on a broad range of covered issues.

The cost of the MetLife Base Plan has covered services such as coverage for divorce without an hour limit, probate, custody and child support matters, and personal property matters.

With the **MetLife Enhanced Plan**, you have all the covered services in the Base Plan plus fully covered attorneys' fees for trusts, affidavits, traffic tickets, deeds, and tenant negotiations. You also have 20 hours available for reproductive matters, which includes surrogacy, egg donation, embryo donation, and more.

Finally, cover your loved ones with the **MetLife Enhanced Plan–Plus Parents**. With this plan, you and your dependents will be covered under the Enhanced Plan design. This plan also covers *up to eight parents* in your legal plan and provides them access to services, including estate planning and elder-care issues. Parent(s) are only covered for a subset of full plan coverage.

Legal plan billing is handled by Empyrean. Plan payments can be made to them by direct debit or check. Additional information on covered benefits can be found at https://www.llnl.gov/join-our-team/benefits/health-welfare/legal-insurance.

Legal Insurance (Monthly Rate)	
Base Plan	$12.30
Enhanced	$18.30
Enhanced + Parents	$24.30

Vision Plans

You have a choice of vision plans–the discount program called "Vision Discount" or a comprehensive vision care plan called "Vision Choice". Both plans are offered through Vision Service Plan (VSP). The Vision Discount program has no monthly premium cost to you. Eligible retirees and dependents have been automatically enrolled. You will remain enrolled in the Vision Discount if you do not elect the Vision Choice plan. For the Vision Choice plan, the monthly premium is fully paid by you.

See the chart on page 37 for a comparison of the benefit coverages for the two options. To locate a VSP provider, log on to www.vsp.com or call **(800) 877-7195**. To enroll in the Vision Choice plan, contact Empyrean at **(844) 750-5567** or log on to www.llnsretireebenefits.com.

NOTE: If you do not make any changes to your vision plan for 2023, you will remain enrolled in your current Vision plan.

Vision - Monthly Rates	Vision Discount	Vision Choice
Retiree Only	$0	$10.22
Retiree & Spouse / Registered Domestic Partner	$0	$20.46
Retiree & Child(ren)	$0	$21.89
Retiree & Family	$0	$34.99

Accidental Death & Dismemberment (AD&D)

There are no plan design or rate changes in 2023. 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. Coverage details for 2023 are available by contacting AIG at **(800) 772-7863**.

2023 AD&D Monthly Rates Per $1,000 of Coverage	
Retiree Only	$0.90
Retiree & Spouse	$1.40
An age-based benefit reduction will begin at age 70 on the following schedule:	
Age	Percent of Benefit
<70	100%
70 – 75	65%
75 – 80	45%
80 – 85	30%
85+	15%

Medicare "Split Family" Enrollment

When a retiree and/or dependent reaches age 65, he or she becomes eligible to participate in a Medicare plan. If a retiree is Medicare eligible and a spouse/domestic partner is not (or vice versa), this is known as a "split family". Each person's corresponding available options will appear on the enrollment worksheet you will receive from Empyrean and on the LLNS Retiree Benefits website so that separate elections can be made. All retirees and dependents in a "split family" situation are able to review and make separate elections based on their individual eligibility. If you or your dependent are becoming Medicare eligible in 2023 you will receive information on your new enrollment options about 120 days prior to your or your dependent's 65th birthday.

Direct Debit

You can authorize Empyrean to deduct the balance due each month from your personal bank account. Direct debit is easy to set up and secure. If you are interested in setting up direct debit, you can enroll online at www.llnsretireebenefits.com and click the Billing Services link on the homepage or you can call Empyrean at (844) 750-5567 and select option 1 to request an ACH Form. Deductions are made approximately the fifth business day of the month.

Beneficiaries

Open Enrollment is a good time to review your beneficiary designations. You may change your designated beneficiary at any time and once your new designations are processed, all previous designations are invalid.

Contact the following organizations to change your beneficiary designation:

LLNS 401(k) plans	Fidelity	800-835-5095
AD&D	AIG	800-772-7863
Pension Single Sum Death Benefit (TCP1)	LLNS Pension Center	866-655-9587
UCRP Lump Sum Death Benefit	UCRP	800-888-8267
PERS Death Benefit	PERS	888-225-7377

Be sure to contact Empyrean at (844) 750-5567 to: Update Your Address / Report A Death

REQUIRED NOTICES

Notice of Availability of Notice of Privacy Practices

The LLNS Health and Welfare Benefit Plan for Retirees (the "Plan") provides health benefits to eligible retirees of Lawrence Livermore National Security, LLC (the "Company") and their eligible dependents as described in the Summary Plan Description for the Plan. The Plan creates, receives, uses, maintains, and discloses health information about participating retirees 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 Benefits web site http://benefits.llnl.gov (select "Retirees" tab and click on "Privacy Notice").

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 re-constructive 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:

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.

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. This information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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.

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) to join a Part D plan because you lost creditable coverage. 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 Via Benefits 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's 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.

Contact Via Benefits at **(866) 682-4841** 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.

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, unless you sign up to recieve it electronically. 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 **(877) 486-2048**.

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 **(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 **(800) 464-4000**.The Anthem Blue Cross medical options do not require the designation of a primary care provider.

HIPAA Special Enrollment Rights (Health Insurance Portability and Accountability Act of 1996)

If you are declining enrollment in medical/dental coverage for yourself or your eligible dependents (including your spouse, registered domestic partner, dependent children and registered 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/ dental coverage if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). **In addition, if you have a new dependent due to marriage, birth, adoption, or placement for adoption, 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, or placement for adoption**. Contact Empyrean at **(844) 750-5567** for more information.

SUMMARY OF BENEFITS AND COVERAGES

Notice of Availability

The Affordable Care Act passed in 2010 requires group health plans to provide participants with a uniform Summary of Benefits and Coverage (SBC) that allows individuals to compare medical plan options on an "apples-to-apples" basis across insurance companies, employer plans, etc. For LLNS, there is a SBC for each group medical plan option:

- Anthem Blue Cross Plus
- Anthem Blue Cross PPO
- Anthem Blue Cross EPO
- Anthem Blue Cross CoreValue
- Anthem Blue Cross HDHP
- Kaiser Permanente

The SBCs for LLNS' plans are posted on the Empyrean LLNS Retiree website www.llnsretireebenefits.com or on the LLNS Benefits website https://benefits.llnl.gov. You also have the right to request a hard copy of the SBC(s) free of charge by calling the Empyrean Customer Care center at **(844) 750-5567**.

Please note that these SBCs do not apply to you if your coverage is through an individual policy administered by Via Benefits.

SUMMARY ANNUAL REPORT

For LLNS Health and Welfare Benefit Plan for Retirees

This is a summary of the annual report of the LLNS Health & Welfare Benefit Plan for Retirees (Employer Identification Number 20-5624386, Plan Number 502) for the plan year 01/01/2021 through 12/31/2021. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Lawrence Livermore National Security, LLC has committed itself to pay certain medical and dental claims incurred under the terms of the plan.

Insurance Information

The plan has insurance contracts with Kaiser Foundation Health Plan Inc., Delta Dental of California, National Union Fire Ins. Co. of Pittsburgh, PA, ARAG Insurance Company and Vision Service Plan to pay certain medical, dental, vision, accidental death and dismemberment and legal claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2021 were $38,259,685.

Because they are so called "experience-rated" contracts, the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending 12/31/2021, the premiums paid under such "experience-rated" contracts were $238,905 and the total of all benefit claims paid under these experience-rated contracts during the plan year was $239,686.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- Insurance information, including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write or call the plan administrator, at 7000 East Avenue Mail Stop L-642, Livermore, CA 94550 and phone number, 925-422-9955.

You also have the legally protected right to examine the annual report at the main office of the plan: 7000 East Avenue Mail Stop L-642, Livermore, CA 94550, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average less than one minute per notice (approximately 3 hours and 11 minutes per plan). Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0040 (expires 07/31/2023).

MED

ICAL

FOR THOSE NOT ELIGIBLE FOR MEDICARE

Plan Changes for 2023

- Anthem Blue Cross has added access to Health Guides for all of their plans. A health guide is a concierge-level customer service expert ready to answer questions, advocate for your health and explain how to use your benefits. You can call a health guide or chat from your mobile device using the Sydney Health app.
- Rates for 2023 will be provided by Empyrean in a separate mailing.
- IMPORTANT: Details are contained in the medical plan comparison chart that begins on page 28.
- Be sure to carefully review this information.

Anthem Blue Cross Plus, PPO, and Core Value

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 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 meet the family deductible, 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.

What You Need To Do During Open Enrollment

Review all information received.

Empyrean will continue to administer non-Medicare eligible enrollees for medical coverage.

Empyrean will continue to administer dental, legal and vision coverages for all retirees and their eligible dependents.

You will receive a Personal Enrollment Worksheet from Empyrean in early October that provides all available options and rates, as well as your default coverage if you do not make any changes.

You can also view your options and rates online at www.llnsretireebenefits.com. Carefully review all Open Enrollment information you receive to make the best decision for your situation.

If no changes are made during Open Enrollment, you will remain in the same plans.

Contact Empyrean

P.O. Box 2307 Bellaire, TX 77402
(844) 750-5567
www.llnsretireebenefits.com

- To make your elections, changes, or cancellations.
- To set up Direct Debit payment of your account balance.

After your election has been made, a confirmation statement will be mailed to your address of record.

Please note that Empyrean Open Enrollment lines open at 7:00 a.m. Pacific time on Monday, October 24, 2022.

The last day to make an election is Friday, November 11, 2022, 5:00 p.m. Pacific time.

Medical Plan Choices

You are encouraged to evaluate your options to ensure that the choice you made for the current year still meets your needs. A more detailed explanation of plan coverages and exclusions are available from Empyrean. The **Non-Medicare** plans available for 2023 include:

- Kaiser Permanente CA
- Anthem Blue Cross PPO
- Anthem Blue Cross EPO
- Anthem Clue CrossCore Value
- Anthem Blue Cross Plus
- Anthem High Deductible Plan HDHP

If you or your dependent becomes eligible for Medicare before age 65, contact Empyrean at **(844) 750-5567**.

All Anthem plans use the same network as the Anthem Blue Cross PPO, providing a nation-wide network for coverage. A more detailed explanation of plan coverages and exclusions are available from the carrier.

Health Savings Account (HSA)

The Anthem Blue Cross Core Value plan and Anthem HDHP are HSA compatible. An HSA is a tax-advantaged account which can be used to save money for eligible medical expenses. If you enroll/are enrolled in the Core Value option or the HDHP you can set up an HSA through most financial institutions. The financial institution will provide you with details about eligible expenses, how much you can contribute, etc. NOTE: If you are enrolled in any other medical plan, including Medicare (Part A and/or B), you are not eligible for the HSA.

Mandatory Maintenance Prescription Mail Order Program

For Anthem Blue Cross plans, the mandatory mail order program for maintenance medications remains in effect in 2023. 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 **(866) 623-1438** with any questions you may have about their services.

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.

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 that begins on page 28 for benefit details.

FOR

THOSE MEDICARE ELIGIBLE AND CURRENTLY IN KAISER PERMANENTE SENIOR ADVANTAGE (KPSA)

KPSA in CA will be:
$227.83/MONTH/PERSON

No Changes for 2023

What You Need To Do During Open Enrollment

Review all information received

Carefully review all Open Enrollment information you receive to make the best decision for your situation.

If you want your coverage to remain with Kaiser, do nothing this Open Enrollment and your coverage will continue with Kaiser.

If you change your Medicare plan to Via Benefits, a Kaiser dis-enrollment form is required to complete the transaction, contact Empyrean for this form.

Empyrean will continue to administer KPSA of California coverage for Medicare eligible enrollees with their HRA administered by Kaiser.

Via Benefits will continue to administer medical benefits and the HRA for all Medicare eligible enrollees not in KPSA of California.

You must be enrolled in KPSA (Outside of California) or a medical plan through Via Benefits to receive the HRA for 2023.

Please note that Empyrean Open Enrollment lines open at 7:00 a.m. Pacific time on Monday, October 24, 2022. The last day to make an election is Friday, November 11, 2022, 5:00 p.m. Pacific time.

Contact Empyrean

(844) 750-5567

www.llnsretireebenefits.com

Suspend your Kaiser coverage to elect medical through Via Benefits if you want to change your medical coverage to a plan other than Kaiser. You will then need to contact Via Benefits at **(866) 682-4841** to enroll in another medical plan. If you elect a plan other than KPSA, all Medicare eligible participants in your family must also select a new plan through Via Benefits.

- For vision plan enrollment/changes/cancellations.
- For dental plan enrollments/changes/cancellations.
- For legal plan enrollments/changes/cancellations.
- To change your address or report a death.
- To set up Direct Debit for automatic payment of your account balance.

Health Reimbursement Arrangement (HRA)

Each year LLNS contributes a designated amount to your HRA—a special, tax-free, employer-funded account you use to pay for eligible medical expenses and prescription drugs. The employer contribution is prorated to your graduated eligibility based on your years of service determined at the time of your retirement. **For 2023, the maximum contribution will remain at $2,450 for each Medicare eligible retiree and Medicare eligible dependent.**

Any unused amount in your HRA will rollover to the next year. Further details about KPSA of California coverage and the HRA are available from the Kaiser HRA Payment Center at **(877) 761-3399**.

Your benefit dollars will be placed in an HRA account that you can use to pay for eligible medical expenses and prescription drugs.

You pay the full cost of your KPSA of California premiums and can use the money in your HRA account for reimbursement of this cost.

If you made arrangements to have HRA payments made directly to Empyrean they will automatically continue in 2023. If you would like to opt out of HRA payments being made directly to Empyrean please contact the Kaiser HRA payment Center at (877) 761-3399.

NOTE: The Kaiser plan does not have the prescription drug coverage gap, so the special payment does not apply to KPSA enrollees.

Contact the Kaiser HRA Payment Center to:

Request reimbursement for out of pocket medical or prescription expenses.

(877) 761-3399

If one Medicare eligible person in your family elects KPSA, then all Medicare eligible persons must enroll. You cannot split between KPSA and an individual Medicare plan through Via Benefits.

FOR THOSE MEDICARE ELIGIBLE AND NOT IN KAISER PERMANENTE SENIOR ADVANTAGE (KPSA) IN CALIFORNIA

Changes for 2023

The Medicare Prescription "gap" special payment for enrollees not in KPSA will change in 2023, see page 27 for details.

What You Need To Do During Open Enrollment

Review all information received

The Personal Enrollment Worksheet you receive from Empyrean provides all available options and rates which are offered through Empyrean. Plan offerings through Via Benefits are not represented in this Worksheet. If your current medical plan election states "No Coverage" this may be because you have enrolled in a plan through Via Benefits or have suspended your coverage.

Via Benefits will continue to administer health care benefits for Medicare eligible enrollees not enrolled in Kaiser of California. Carefully review all Open Enrollment information you receive to make the best decision for your situation.

If you do not make a new plan selection with Via Benefits, you will remain in the same plan in 2023.

You must be enrolled in a medical plan through Via Benefits or Kaiser (Outside of California) to receive the HRA for 2023.

If you have been notified that your current plan will be terminating, you must contact Via Benefits to select a new plan.

Please note that while your plan will continue in 2023, benefits and costs may change. Review all information from your individual plan.

There are limitations on when you can change plans with certain Medicare plans. Make sure to discuss your options with a Via Benefits Benefit Advisor.

Via Benefits

Via Benefits will continue to administer health care benefits (except for KPSA in California) for Medicare-eligible retirees and their Medicare-eligible dependent(s), providing you with a wide array of coverage options and allowing you to personalize your coverage and control your costs. (Dental, Vision and Legal plan coverage remain with Empyrean)

As experts in the Medicare market, Via Benefits Benefit Advisors can help you find and enroll in a plan that best fits your needs and budget. Coverage for non-Medicare eligible enrollees remains with Empyrean. If you or any eligible family member becomes Medicare eligible midyear the coverage will be moved to Via Benefits unless you enroll in KPSA in California.

If you are satisfied with your current health care coverage and do not wish to make any changes, there is no need to contact Via Benefits. If you have been notified that your current plan will be terminating, you must contact Via Benefits to select and enroll in another plan.

*Via Benefits offers individual dental and vision plans for you to purchase. However, there is a cost. Make sure to compare benefits and costs against LLNS benefits offered through Empyrean before purchasing.

Contact Via Benefits

(866) 682-4841

www.viabenefits.com

- If you want to find and enroll in a different medical plan and/or prescription drug plan.
- To cancel the plan you are currently enrolled in.

Please note that Via Benefits Open Enrollment lines open at **5:00 a.m. Pacific time on Saturday, October 15, 2022**. The last day to make an election is **Wednesday, December 7, 2022, 6:00 p.m. Pacific time**.

Contact Empyrean

(844) 750-5567

www.llnsretireebenefits.com

- For vision plan enrollment changes.
- For dental plan enrollments/changes/cancellations.
- For legal plan enrollments/changes/cancellations.
- If you wish to enroll or dis-enroll from KPSA in California.

Please note that Empyrean Open Enrollment lines open at 7:00 a.m. Pacific time on Monday, October 24, 2022. The last day to make an election is Friday, November 11, 2022, 5:00 p.m. Pacific time. After your election has been made, a confirmation statement will be mailed to your address of record.

California Birthday Rule

(Applies in California only. New York, Connecticut, Oregon, Maine, and Missouri have similar laws.)

California has a unique supplement law known as the birthday rule that allows residents to enroll for Medicare supplements with a different insurance company for 60 days following their birthday without medical underwriting. The new Medigap plan must offer either the same benefits or fewer benefits, and companies are not allowed to deny new applicants for health reasons. (This rule does not apply to Medicare Advantage plans).

KPSA Outside of California

KPSA is available to retirees living outside California (in parts of Colorado, Georgia, Hawaii, Oregon, Washington, and mid-Atlantic states (Maryland, Virginia, and Washington DC)). If you live outside California and want to change to the KPSA plan, here are the steps to enroll:

Call Kaiser at **(866) 955-8510** to request an individual enrollment kit for your area or log on to kp.org/Medicare.

Complete the Kaiser Permanente Medicare enrollment form and send it in per the instructions on the form.

After you receive confirmation of your enrollment, notify Via Benefits by submitting proof of enrollment (e.g. KPSA card, enrollment letter). Via Benefits will continue to administer the HRA for retirees enrolled in a KPSA plan outside of California. The address is:

Lisa Starr

Willis Towers Watson Via Benefits 10975 S. Sterling View Drive, Suite 1A

Salt Lake City, UT 84095

Via Benefits will send you an HRA enrollment kit after receiving your confirmation of enrollment in a KPSA plan.

Health Reimbursement Arrangement (HRA)

Each year LLNS contributes a designated amount to your HRA—a special, tax-free, employer-funded account you use to pay for eligible medical expenses and prescription drugs. You must be enrolled in a Medicare plan through Via Benefits to be eligible for the HRA funds. The employer contribution is prorated to your graduated eligibility based on your years of service determined at the time of your retirement. For 2023, the maximum contribution will remain at $2,450 for each Medicare eligible retiree and Medicare eligible dependent. There is no reimbursement for Part B but your HRA money can be used for this expense. Any unused amount in your HRA will rollover to the next year. Further details about the HRA are available from Via Benefits. Your benefit dollars will be placed in an HRA account that you can use to pay for eligible medical expenses and prescription drugs.

- You pay the full cost of your premiums and can use the money in your HRA account for reimbursement of this cost.
- Check with Via Benefits to see if your medical and prescription drug plans are eligible for auto reimbursement.

Medicare Prescription Drug "Gap" Special Payment

LLNS makes a special payment to Medicare enrollees who reach the prescription drug "gap" during the year. When you reach Medicare's initial coverage limit of $4,660 in 2023, you will pay 25% of the cost for your prescription medications until you spend a total of $7,400 out of pocket. Beginning January 1, 2023, the maximum LLNS special payment benefit will be $1,850, representing your 25% of the $7,400.

This payment will be a prorated amount based on the month the coverage limit is reached. It will be calculated using a ratio of the number of months left in the current year divided by twelve, times that year's estimated amount. For example, the 2023 gap amount is estimated to be $1,850; if the coverage gap is reached in October, the special payment would be 3/12 times $1,850 or $462.50.

To be eligible for the HRA and the "coverage gap" special payment through Via Benefits, you must be enrolled in a medical plan through Via Benefits. For more information contact Via Benefits Administrators at (866) 682-4841.

The deadline to submit your claim for the 2023 special payment is March 31, 2024.

2023

MEDICAL PLAN OPTIONS

COMPARISON OF BENEFIT COVERAGES

2023 MEDICAL PLAN OPTIONS COMPARISON OF BENEFIT COVERAGES

FOR THOSE NOT MEDICARE ELIGIBLE

FOR THOSE MEDICARE ELIGIBLE

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser	Kaiser Senior Advantage
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	1-800-443-0815 (KPSA Member Services)
Website	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.kp.org/llns	www.kp.org/llns
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	$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	No Out-of-Network Coverage
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	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	No Out-of-Network Coverage
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 A family must satisfy the family out of pocket maximum before the out of pocket maximum will be met for any family member	$1,500 Individual; $3,000 Family; copays included; excluding durable medical equipment, prescription drugs and infertility services	$1,500 Individual; $3,000 Family: Copay 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	No Out-of-Network Coverage
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	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	No Out-of-Network Coverage

Note: If there is a discrepancy between the benefits as described in the charts and the plan administrator's systems, the plan administrator's system governs for determining benefit coverage.

2023 MEDICAL PLAN OPTIONS COMPARISON OF BENEFIT COVERAGES

FOR THOSE NOT MEDICARE ELIGIBLE

FOR THOSE MEDICARE ELIGIBLE

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser	Kaiser Senior Advantage
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	$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	Not Applicable
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	$35 copay	$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	Not Applicable
Preventive Care	In Network - 100% covered	In Network - 100% covered	In Network - 100% covered	100% covered	In Network - 100% covered	100% covered; for preventive	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	No coverage Out-of-Network
Mammogram	In Network - Diagnostic: $35 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	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	No coverage Out-of-Network
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	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	No coverage Out-of-Network

Note: If there is a discrepancy between the benefits as described in the charts and the plan administrator's systems, the plan administrator's system governs for determining benefit coverage.

2023 MEDICAL PLAN OPTIONS COMPARISON OF BENEFIT COVERAGES

FOR THOSE NOT MEDICARE ELIGIBLE

FOR THOSE MEDICARE ELIGIBLE

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser	Kaiser Senior Advantage
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	Diagnostic and testing: $25 copay per visit; allergy injection: $3 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	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	$150 copay; per procedure	$25 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	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	$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	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	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	Refer to EOC

Note: If there is a discrepancy between the benefits as described in the charts and the plan administrator's systems, the plan administrator's system governs for determining benefit coverage.

2023 MEDICAL PLAN OPTIONS COMPARISON OF BENEFIT COVERAGES

FOR THOSE NOT MEDICARE ELIGIBLE

FOR THOSE MEDICARE ELIGIBLE

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser	Kaiser Senior Advantage
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	$250 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	No coverage Out-of-Network unless medical emergency
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	$50 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	Check with Plan
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	$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	Check with Plan
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	$50 Copay Per Trip
	Out of Network - 80% covered after deductible is met; no copay if true emergency; 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 - 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 - 90% covered after deductible is met; must be medically necessary; subject to Maximum Allowed Amount		$50 Copay Per Trip
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	$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	No coverage Out-of- Network

Note: If there is a discrepancy between the benefits as described in the charts and the plan administrator's systems, the plan administrator's system governs for determining benefit coverage.

2023 MEDICAL PLAN OPTIONS COMPARISON OF BENEFIT COVERAGES

FOR THOSE NOT MEDICARE ELIGIBLE

FOR THOSE MEDICARE ELIGIBLE

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser	Kaiser Senior Advantage
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	$250 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	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	$25 Copay; $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	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	$250 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	Not Applicable
Chiropractic/ Acupuncture	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. Medically refereed acupuncture covered at primary care cost	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	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	Not Applicable

Note: If there is a discrepancy between the benefits as described in the charts and the plan administrator's systems, the plan administrator's system governs for determining benefit coverage.

2023 MEDICAL PLAN OPTIONS COMPARISON OF BENEFIT COVERAGES

FOR THOSE NOT MEDICARE ELIGIBLE

FOR THOSE MEDICARE ELIGIBLE

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser	Kaiser Senior Advantage
Prescription Drug Vendor	Caremark	Caremark	Caremark	Caremark	Caremark	Kaiser	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	1-800-443-0815 (KPSA Member Services)
Prescription Drug Web Site	www.caremark.com	www.caremark.com	www.caremark.com	www.caremark.com	www.caremark.com	www.kp.org/llns	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	Not applicable
Prescription Benefits Are Covered Under Medical Deductible	No	No	Yes	No	Yes	Not applicable	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 out-of-pocket maximum is met, Rx is 100% covered for the remainder of the calendar year	Not applicable	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	$15 for up to a 30-day supply; $45 for up to a 100-day supply; at Kaiser Pharmacy; as prescribed by Plan Physician	$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	$25 for up to a 30-day supply; $75 for up to 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	Covered only when determined medically necessary by a plan physician Note: Most specialty drugs have a 20% coinsurance (not to exceed $150) for up to 100-day supply.

Note: If there is a discrepancy between the benefits as described in the charts and the plan administrator's systems, the plan administrator's system governs for determining benefit coverage.

	DELTA DENTAL PPO	DELTACARE DHMO (AVAILABLE IN CA ONLY)
Member Services	1-800-777-5854	1-800-422-4234
Website	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

Note: If there is a discrepancy between the benefits as described in the charts and the plan administrator's systems, the plan administrator's system governs for determining benefit coverage.

	VISION DISCOUNT	VISION CHOICE PLAN
Frequency (Exam/Lenses/ Frame)	Once per calendar year (12/12/12)	12/12/12 January/January/January
Copay	$50 with purchase of complete pair of glasses 20% without purchase	$10 exam/$25 materials
Diabetic Eyecare Plus	N/A	$20 copay per visit
Frames	25% savings when a complete pair of prescription glasses is purchased	$150 frame allowance
Lenses	With purchase of a complete pair of glasses: Single vision - $40 Lined bifocals - $60 Lined trifocals - $75	Covered after $25 materials Copay
Lens Enhancements	Average savings of 20-25% Progressive Scratch-resistant Anti-reflective coating UV treatment	Standard progressive - $0 Premium progressive - $25 Polycarbonate - $31-35 Anti-reflective coating UV treatment - $10-16
Contact Lenses	15% savings on contact lens exam (fitting and evaluation)	$130
Retinal Screening	Guaranteed pricing with exam, not to exceed $39	
Laser Vision Correction	Average 15% off the regular price of 5% of promotional price; discounts only available from contracted facilities	
Monthly Cost	$0	See rates on page 11

Note: If there is a discrepancy between the benefits as described in the charts and the plan administrator's systems, the plan administrator's system governs for determining benefit coverage.

PLAN CONTACTS		
Carrier // Plan	URL	Telephone #
Empyrean	www.llnsretireebenefits.com	(844) 750-5567
Via Benefits	www.llnsretireebenefits.com	(866) 682-4841
Medicare	www.medicare.gov	(800) 633-4227
Social Security Administration	www.ssa.gov	(800) 772-1213
Kaiser Permanente CA	www.kp.org/llns	(800) 464-4000
Kaiser Senior Advantage	www.kp.org/llns	(800) 443-0815
Kaiser HRA	www.kp.org/healthpayment	(877) 761-3399
Anthem Blue Cross EPO	www.anthem.com/ca/llns	(866) 641-1689
Anthem Blue Cross PLUS	www.anthem.com/ca/llns	(866) 641-1689
Anthem Blue Cross PPO	www.anthem.com/ca/llns	(866) 641-1689
Anthem Blue Cross Core Value	www.anthem.com/ca/llns	(866) 641-1689
Anthem Blue Cross HDHP	www.anthem.com/ca/llns	(866) 641-1689
CVS/Caremark	www.caremark.com	(866) 623-1438
Delta Dental PPO	www.deltadentalins.com/llns	(800) 777-5854
Delta Care DMO	www.deltadentalins.com/llns	(800) 422-4234
Vision Service Plan	www.vsp.com	(800) 877-7195
Metlife Legal	www.legalplans.com	(800) 821-6400
AD&D AIG		(800) 772-7863

2023 RETIREE BENEFITS
OPEN ENROLLMENT DATES

October 24, 2022 through November 11, 2022

Open enrollment for non-Medicare retirees and Medicare-eligible retirees in Kaiser.

Please note Empyrean Open Enrollment lines open at 7:00 a.m. Pacific time on Monday October 24, 2022 and the last day to make an election is Friday November 11, 2022 5:00 p.m. pacific time.

October 15, 2022 through December 7, 2022

Open enrollment for Medicare-eligible retirees.

Please note Via Benefits Open Enrollment lines open at 5:00 a.m. Pacific time on Saturday October 15, 2022 and the last day to make an election is Wednesday, December 7, 2022 6:00 p.m. Pacific time.

LLNL will be offering a live-virtual presentation option that will be hosted by each of our retiree vendors. Please see the registration information below if you would like to attend.

Empyrean 2023 Virtual Open Enrollment Presentation

Date: Wednesday October 19, 2022

Time: 9:00 a.m. – 10:00 a.m. Pacific Standard Time

Go to https://goempyrean.zoom.us/j/98364803252?pwd=Q01HZjVYakZ6L-2RJNjFyRnVlaitVUT09 and login for this event.

Via Benefits 2023 Virtual Open Enrollment Presentation

Date: Monday October 17, 2022

Time: 10:30 a.m. – 11:30 a.m. Pacific Standard Time

Go to https://attendee.gotowebinar.com/register/7301963798349693455 and login for this event .

Both presentations will be recorded so if you cannot make the live event you can view the recorded presentation on the vendor's website.