



LAWRENCE
LIVERMORE
NATIONAL SECURITY
— LLC —

PLAN COMPARISON CHARTS

2026 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	Kaiser Senior Advantage
Member Services	1-866-641-1689 www.anthem.com/ca/llns/	1-866-641-1689 www.anthem.com/ca/llns/	1-866-641-1689 www.anthem.com/ca/llns/	1-866-641-1689 www.anthem.com/ca/llns/	1-866-641-1689 www.anthem.com/ca/llns/	1-800-464-4000 https://choose.kp.org/llns	1-800-443-0815 https://choose.kp.org/llns
Annual Deductible (Individual/Family, In Network)	\$300 / \$900	\$500 / \$1,500	\$3,000 / \$6,000	\$0 / \$0	\$1,700 / \$3,400	\$0 / \$0	\$0 / \$0
Annual Deductible (Individual/Family, Out of Network)	\$500 / \$1,500	\$1,000 / \$3,000	No Coverage	\$3,300 / \$6,600	No Coverage	No Coverage	No Coverage
Coinsurance Percentage (In Network)	80%	80%	80%	90%	90%	100%	100%
Coinsurance Percentage (Out of Network)	60%	60%	60%	No Coverage	70%	No Coverage	No Coverage
Out-of-pocket Maximum (Individual/Family, In Network)	\$2,500 / \$7,500	\$3,000 / \$9,000	\$5,000 / \$10,000	\$1,000 / \$3,000	\$3,000 / \$6,000	\$1,500 / \$3,000	\$1,500 / \$3,000
Out-of-pocket Maximum (Individual/Family, Out of Network)	\$7,000 / \$21,000	\$6,000 / \$18,000	\$10,000 / \$20,000	No Coverage	\$6,000 / \$12,000	No Coverage	No Coverage
Ability To Self-Refer to Specialists	Yes	Yes	Yes	Yes	Check guidebook	Check guidebook	Check guidebook

Note: If there is a discrepancy between the benefits as described in the charts and the benefits as described in the Summary of Benefits and Coverage, Evidence of Coverage documents or other plan administrator's systems (together "Plan Administrator's Systems"), the Plan Administrator's Systems govern for determining benefit coverage.

2026 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	Kaiser Senior Advantage
Primary Doctor Office Visit	In Network - \$25 copay Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	In Network - 80% covered after deductible is met Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	In Network - 80% covered after deductible is met Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	\$25 copay No coverage Out-of-Network	In Network - 90% covered after deductible is met Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	\$25 copay No coverage Out-of-Network	\$25 copay No coverage Out-of-Network
Specialist Office Visit	In Network - \$35 copay Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	In Network - 80% covered after deductible is met Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	In Network - 80% covered after deductible is met Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	\$35 copay No coverage Out-of-Network	In Network - 90% covered after deductible is met Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	\$35 copay No coverage Out-of-Network	\$25 copay No coverage Out-of-Network
Preventive Care	In Network - 100% covered Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	In Network - 100% covered Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	In Network - 100% covered Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	100% covered No coverage Out-of-Network	In Network - 100% covered Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	100% covered; for preventive No coverage Out-of-Network	100% covered; for preventive No coverage Out-of-Network
Mammogram	In Network - Diagnostic: 80% covered after deductible is met; 100% covered for preventive care Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	In Network - Diagnostic: 80% covered after deductible is met; 100% covered for preventive care Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	In Network - Diagnostic: 80% covered after deductible is met; 100% covered for preventive care Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Diagnostic: 90% covered; 100% covered for preventive care No coverage Out-of-Network	In Network - Diagnostic: 90% covered after deductible is met; 100% covered for preventive care Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	100% covered for preventive care No coverage Out-of-Network	100% covered for preventive care No coverage Out-of-Network
Immunizations (child and adult)	In Network - 100% covered for preventive care Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	In Network - 100% covered for preventive care Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	In Network - 100% covered for preventive care Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	100% covered for preventive care No coverage Out-of-Network	In Network - 100% covered for preventive care Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	100% covered for preventive care No coverage Out-of-Network	100% covered for preventive care No coverage Out-of-Network

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	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	In Network - Diagnostic test/ diagnostic treatment: 90% covered after deductible is met
Outpatient x-ray and laboratory services	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
Outpatient Physical, Speech And Occupational Therapy	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
Fertility Services	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 60 visits per year combined physical, speech and occupational therapy, in-network and out-of-network; subject to Maximum Allowed Amount	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; subject to Maximum Allowed Amount	\$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; subject to Maximum Allowed Amount	\$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	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	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	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	No coverage Out-of-Network	No coverage Out-of-Network
	In Network only - 50% covered after deductible is met; \$20,000 lifetime maximum for all infertility benefits combined; medical and pharmacy	Not covered; IVF 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

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	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	In Network - \$250 copay per admission; then 80% covered after deductible is met; \$200 penalty if non-emergency services are not preauthorized Out of Network - 60% covered after deductible is met; \$200 penalty if non-emergency services are not preauthorized; subject to Maximum Allowed Amount	In Network - 80% covered after deductible is met; \$200 penalty if non-emergency services are not preauthorized; subject to Maximum Allowed Amount Out of Network - 60% covered after deductible is met; \$200 penalty if non-emergency services are not preauthorized; subject to Maximum Allowed Amount	In Network - 80% covered after deductible is met Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	\$250 copay per admission; then 90% covered; \$200 penalty if non-emergency services are not preauthorized No coverage Out-of-Network	In Network - 90% covered after deductible is met Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	\$500 copay per admission No coverage Out-of-Network	\$250 Copay Per Admission No Out-of-Network Coverage, unless medical emergency
Emergency Room (not followed by admission)	In Network - \$100 copay; then 80% covered after deductible is met; copay waived if admitted Out of Network - \$100 copay then 80% covered after deductible is met; copay waived if admitted	In Network - 80% covered after deductible is met Out of Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met Out of Network - 80% covered after deductible is met; non-emergencies subject to Maximum Allowed Amount	In-Network: \$100 copay; then 90% covered after deductible is met; copay waived if admitted Out-of-Network: \$100 copay for emergencies then 90% covered after deductible is met; copay waived if admitted	In Network - 90% covered after deductible is met Out of Network - 90% covered after deductible is met	\$100 copay; waived if admitted \$100 copay; waived if admitted	\$50 Copay; waived if admitted Check with Plan
Urgent Care Clinic Visit	In Network - \$25 copay Out of Network - 60% covered; after deductible is met; subject to Maximum Allowed Amount	In Network - 80% covered after deductible is met Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	In Network - 80% covered after deductible is met Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	\$25 copay No coverage Out-of-Network	In Network - 90% covered after deductible is met Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	\$25 copay; per visit \$25 copay; per visit; non-Plan providers covered when outside the service area	\$25 Copay; Per Visit Check with Plan
Ambulance Services	In Network - 80% covered after deductible is met; must be medically necessary Out of Network - 80% covered after deductible is met; no copay if true emergency; must be medically necessary; subject to Maximum Allowed Amount	In Network - 80% covered after deductible is met; must be medically necessary Out of Network - 80% covered after deductible is met; must be medically necessary; subject to Maximum Allowed Amount	In Network - 80% covered after deductible is met; must be medically necessary Out of Network - 80% covered after deductible is met; must be medically necessary; subject to Maximum Allowed Amount	In Network - 90% covered; must be medically necessary Out of Network - 90% covered; must be medically necessary; subject to Maximum Allowed Amount	In Network - 90% covered after deductible is met; must be medically necessary Out of Network - 90% covered after deductible is met; must be medically necessary; subject to Maximum Allowed Amount	\$50 copay per trip	\$50 Copay Per Trip
Mental Health:	In-network: 80% covered after deductible is met	In-network: Behavior Health visits, the deductible is waived; co-pay is \$25.	In-network: Behavior Health visits, the deductible is waived; co-pay is \$25.	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
Outpatient Coverage	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*

* You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If Health Plan fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you do not have to pay anything other than your ordinary in-network cost-sharing. If you do not need the services urgently, your health plan must offer an appointment.

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Mental Health: Inpatient Coverage	In-network: 80% covered after deductible is met Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	In-network: \$25 copay with no deductible Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	In-network: 80% covered after deductible is met Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	In-network: 90% covered No Out-of-Network Coverage	In-network: 90% covered after deductible is met Out-of-network: 70% covered after deductible is met; subject to Maximum Allowed Amount	\$500 copay per admission No Out-of-Network Coverage	\$250 copay per admission No Out-of-Network Coverage
Substance Abuse: Outpatient Coverage	In-network: 80% covered after deductible is met Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	In-network: \$25 copay with no deductible Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	In-network: 80% covered after deductible is met Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	In-network: \$0 copay for visits 1-5; \$25 copay for visits 6 and over No Out-of-Network Coverage	In-network: 90% covered after deductible is met Out-of-network: 70% covered after deductible is met; subject to Maximum Allowed Amount	\$25 copay individual visit; \$5 copay group visit; unlimited visits No Out-of-Network Coverage	\$25 copay individual visit; \$5 copay group visit; unlimited visits No Out-of-Network Coverage
Substance Abuse: Inpatient Coverage	In-network: 80% covered after deductible is met Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	In-network: 80% covered after deductible is met Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	In-network: 80% covered after deductible is met Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	In-network: 90% covered No Out-of-Network Coverage	In-network: 90% covered after deductible is met; subject to Maximum Allowed Amount Out-of-network: 70% covered after deductible is met; subject to Maximum Allowed Amount	\$500 copay per admission; \$100 copay for transitional residential recovery services; mental health/chemical dependency services accrue to out-of-pocket minimum No Out-of-Network Coverage	\$250 copay per admission; \$100 copay for transitional residential recovery services; mental health/chemical dependency services accrue to out-of-pocket minimum No Out-of-Network Coverage
Chiropractic/ Acupuncture	In Network - \$25 copay; limited to 25 visits per calendar year Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	In Network - 80% covered after deductible is met; limited to 25 visits per calendar year Out of Network - 60% covered after deductible is met; limited to 25 visits per calendar year; subject to Maximum Allowed Amount	In Network - 80% covered after deductible is met; limited to 25 visits per year; combined in network and out-of-network 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	\$25 copay; limited to 25 visits per calendar year No Out-of-Network Coverage	In Network - 90% covered after deductible is met; limited to 25 visits per year; combined in network and out-of-network Out of Network - 70% covered after deductible is met; limited to 25 visits per calendar year; combined in network and out-of-network; subject to Maximum Allowed Amount	Member discounts available through American Specialty Health network. Medically referred acupuncture at primary care cost No Out-of-Network Coverage	Member discounts available through American Specialty Health Network No Out-of-Network Coverage

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Prescription Drug Vendor	Caremark 1-866-623-1438 www.caremark.com	Caremark 1-866-623-1438 www.caremark.com	Caremark 1-866-623-1438 www.caremark.com	Caremark 1-866-623-1438 www.caremark.com	Caremark 1-866-623-1438 www.caremark.com	Kaiser 1-800-464-4000 https://choose.kp.org/lms	Kaiser 1-800-464-4000 https://choose.kp.org/lms
Member Services	Caremark 1-866-623-1438 www.caremark.com	Caremark 1-866-623-1438 www.caremark.com	Caremark 1-866-623-1438 www.caremark.com	Caremark 1-866-623-1438 www.caremark.com	Caremark 1-866-623-1438 www.caremark.com	Kaiser 1-800-464-4000 https://choose.kp.org/lms	Kaiser 1-800-464-4000 https://choose.kp.org/lms
Website	Caremark 1-866-623-1438 www.caremark.com	Caremark 1-866-623-1438 www.caremark.com	Caremark 1-866-623-1438 www.caremark.com	Caremark 1-866-623-1438 www.caremark.com	Caremark 1-866-623-1438 www.caremark.com	Kaiser 1-800-464-4000 https://choose.kp.org/lms	Kaiser 1-800-464-4000 https://choose.kp.org/lms
Annual Prescription Drug 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 Drug 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 min copay, \$60 max 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 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 min copay, \$100 max 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.

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2026 DENTAL PLAN OPTIONS COMPARISON*

	Delta Dental PPO	Deltacare DHMO (CA Only)
Member Services	1-800-777-5854	1-800-422-4234
Website	deltadentalins.com/ltns	deltadentalins.com/ltns
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 Out of Network - \$50 Individual; combined for both basic and major dentistry; waived for preventive/diagnostic care	\$0 Individual; \$0 Family Not applicable
Annual Maximum Coverage Per Person	Delta Dental PPO Dentist - \$1,700 Non Delta Dental PPO Dentist - \$1,500	Not applicable Not applicable
Preventive Care Benefits	In Network - 100% covered; sealants 80% covered Out of Network - 100% covered of expected cost; sealants 75% covered	\$0-\$45 copays 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 Out of Network - same as in network	Cleaning and fluoride, one per 6 month period, child to age 19 Not applicable
Basic Services (fillings, routine extractions, endodontics, periodontics)	In Network - 80% covered after deductible is met Out of Network - 75% covered after deductible is met	100% covered; for standard benefit; Copay for endodontics, periodontics Not applicable
Major Services (crowns, bridges, implants, dentures)	In Network - 50% covered after deductible is met Out of Network - 50% covered after deductible is met	Copay applies Not applicable
Orthodontia Benefits	In Network - 50% covered Out of Network - 50% covered	\$1,700 - Child; \$1,900 Adult; \$100 Start Up Fee Not applicable
Service Limits and Maximums—Orthodontia	In Network - Limited to \$1,500 per lifetime for dependent children; \$500 per lifetime for adults Out of Network - Limited to \$1,500 per lifetime for dependent children; \$500 per lifetime for adults	Check with plan Not applicable

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2026 VISION PLAN OPTIONS COMPARISON*

	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	In Network - \$10 copay; 30-day supply Out of Network - 50% of average whole price schedule plus charges above the schedule
Laser Vision Correction	Average 15% off the regular price or 5% off promotional price; discounts only available from contracted facilities	In Network - 80% covered; \$40 min copay, \$60 max copay; 30-day supply Out of Network - 50% of average whole price schedule plus charges above the schedule
Monthly Cost	\$0	See rates on page 11

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PLAN CONTACTS

Carrier / Plan	URL	Phone
Empyrean	www.llnsretireebenefits.com	(844) 750-5567
Via Benefits	http://www.viabenefits.com/	(866) 682-4841
Medicare	www.medicare.gov	(800) 633-4227
Social Security Administration	www.ssa.gov	(800) 772-1213
Kaiser Permanente CA	https://choose.kp.org/llns	(800) 464-4000
Kaiser Senior Advantage	https://choose.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		(877) 202-1346

For coverage details go to <https://www.llnl.gov/join-our-team/benefits/annual-open-enrollment>

2026

Retiree Benefits Open Enrollment Dates

October 27, 2025 through November 14, 2025

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 27, 2025. The last day to make an election is Friday, November 14, 2025, 5:00 p.m. Pacific time.

October 15, 2025 through December 5, 2025*

Open enrollment for Medicare-eligible retirees.

*Please note Via Benefits Open Enrollment phone lines open at 5:00 a.m. Pacific time on Wednesday, October 15, 2025 and close Friday, December 5, 2025. The last day to make an election online is Sunday, December 7, 2025, 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 2026 Virtual Open Enrollment Presentation

Date: Wednesday, October 22, 2025 Time: 9:00 a.m. – 10:00 a.m. Pacific Time

Go to [Join the meeting now](#) and login for this event.

Via Benefits 2026 Virtual Open Enrollment Presentation

Date: Monday, October 20, 2025 Time: 10:30 a.m. – 11:30 a.m. Pacific Time

Go to <https://attendee.gotowebinar.com/register/2058120190558589017> and login for this event.