LLNS

Health and Welfare Benefit Plan for Employees

Summary Plan Description

Effective January 1, 2026

IMPORTANT

This Summary Plan Description (“SPD”) is intended to provide a summary of the principal features of the LLNS Health & Welfare Benefit Plan for Employees ("Plan"). Additional information about component Benefit Programs is found in Appendix B. The documents referred to in Appendix B and any updates to those documents are hereby incorporated by reference into the SPD and the Plan.

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

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

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

For questions or to receive a paper copy of this SPD please contact the Lawrence Livermore National Laboratory (LLNL) Benefits Office at 925-422-9955. SPDs are also available electronically at *LLNL Benefits Website for Employees* https://benefits.llnl.gov/.

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1. Introduction

General Information

This Summary Plan Description ("SPD") describes the health and welfare Benefit Programs sponsored by Lawrence Livermore National Security, LLC ("LLNS") and made available to eligible employees of LLNS through the LLNS Health & Welfare Benefit Plan for Employees ("Plan"). For purposes of this Plan, employee means an individual who meets the Eligibility Requirements in Section 2. Eligibility Requirements below.

Please share this SPD with your family members.

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

When the term "family member" or "dependent" is used in this SPD, it generally refers to spouses (as defined under state law), registered domestic partners, and children who are related to an eligible employee. Please read Section 2. Eligibility Requirements very carefully, because each Benefit Program may define the term "dependent" in a slightly different way.

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

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

Plan Details

For detailed information, please refer to:

- Appendix A for Premium Contribution Arrangement information;
- Appendix B for a list of Benefit Program materials;
- Appendix C and Section 8. Claims and Appeals Procedures for claim and appeals administration information;
- Appendix D for funding and contract administration information; and
- Appendix E for COBRA administration contact information
- Appendix F for Plan administration information.

LLNS Benefits

LLNS offers the Benefit Programs listed from time to time in Appendix B. Certain Benefit Programs may not be available to all LLNS employees and dependents. The Benefit Programs that are currently offered under the Plan are:

- Medical
- Dental
- Vision
- Employee Assistance Program (EAP)
- Basic Life
- Core Life
- Supplemental Life
- Dependent Life
- Accidental death and dismemberment (AD&D)
- Supplemental disability
- LLNS Defined Benefit Eligible Disability Program
- Business Travel Accident (BTA)
- Legal
- Dependent Care Reimbursement Account (DCRA)
- Health Care Reimbursement Account (HCRA)
- Severance
- LLNS Defined Benefit Eligible Survivor Income Program
- LLNS Tax-Savings on Insurance Premiums (TIP)

Note that the Tax-Savings on Insurance Premiums (TIP) and Dependent Care Reimbursement Account (DCRA) programs are not subject to ERISA and are not part of the Plan. However, a brief description of the program is included in this document for convenience. Also see the DCRA Benefit Program Summary referenced in Appendix B for more information.

LLNL Benefits Office

For information about your benefits, please contact:

LLNL Benefits Office

Mailing Address
P.O. Box 808, L-640
Livermore, CA 94551

Street Address
7000 East Ave., L-640
Livermore, CA 94550

Telephone: 925-422-9955
Fax: 925-422-8287
https://benefits-int.llnl.gov/ (internal)

https://benefits.llnl.gov (external)

Keep Your Records Updated

Make sure that LLNS always has your current home address and telephone number.

Lawrence Livermore National Lab
Attn: LAPIS
P.O. Box 808, L-631
Livermore, CA 94550
Telephone: 925-422-2444
https://lapis-int.llnl.gov/
Email: LAPIS-HELP@llnl.gov

2. Eligibility Requirements

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

- employee eligibility for health and welfare Benefit Programs; and
- family member eligibility for health and welfare Benefit Programs

Please note that this Section 2. Eligibility Requirements does not describe the eligibility rules for: *LLNS Defined Benefit Eligible Disability Program, LLNS Defined Benefit Eligible Survivor Income Program, or LLNS Business Travel Accident Benefit Program,* which are found in the respective Benefit Program Materials for the respective benefits listed in Appendix B.

Employee Eligibility

An LLNS employee is eligible to participate in the Plan as set forth below.

Initial Requirements

Full Benefits

You are initially eligible to enroll in Full Benefits if you:

- are appointed to work for
  - 12 months or more; and
  - at least 50% time

OR

- have worked 1,000 hours in a calendar year.

Exception: Undergraduate or graduate students are not eligible for Full Benefits.

Mid-level Benefits

You are initially eligible to enroll in Mid-Level Benefits if you are appointed to work:

- 1 or more days, but less than 12 months: and
- at least 43.75%

No Benefits

You are *not* initially eligible for benefits if you:

- are hired to work less than 43.75% per month; or
- are appointed on an indeterminate work schedule; or
- are an undergraduate or graduate student.

Continuing Requirements

After your initial eligibility, LLNS bases your ongoing eligibility for benefits on the number of regular hours you are paid by LLNS to work each week. (Note: regular hours include base pay and exclude bonuses and overtime.)

To remain eligible for your benefit level, you must maintain an average regular paid time of at least 17.5 hours per week for two consecutive months in a rolling 12-month period.

If your average regular paid time drops below 17.5 hours a week for two consecutive months, you become ineligible for all benefits under this Plan.

Health and Welfare Benefit Programs

	Full Benefits	Mid-level Benefits
Medical	x	x
Dental	x	
Vision	x	
Employee Assistance Program (EAP)	x	x
Core Life		x
Basic Life	x	
Supplemental Life	x	x
Dependent Life (Basic and Expanded)	x	x
Accidental Death and Dismemberment (AD&D)	x	x
Supplemental Disability	x	
LLNS Defined Benefit Eligible Disability Program	(certain participants in the LLNS Defined Benefit Pension Plan only)[1]	
Business Travel Accident	x	x
Legal	x	x
Health Care Reimbursement Account (HCRA)	x	x
Dependent Care Reimbursement Account (DCRA)[2]	x	x
Severance	(certain employees only)[1]	
LLNS Defined Benefit Eligible Survivor Income Program	(certain participants in the LLNS Defined Benefit Pension Plan only)[1]	

[1] See Benefit Program materials in Appendix B for eligibility for these benefits.
[2] DCRA is not an ERISA benefit but is included in this SPD for convenience.

Coverages for Family Members

Your family member(s) are eligible only for the Benefit Program(s) in which you have enrolled and the Benefit Program(s) for which they satisfy all requirements for coverage.

For medical benefits family members must be covered under the same Benefit Program option as you.

Eligible Family Members

Family members eligible for coverage under your health and welfare benefits options may include one eligible adult and/or any eligible children.

When the term “dependent” is used in this SPD, it generally refers to spouses, registered domestic partners, children who are related to an eligible employee or registered domestic partner and, in limited cases, an adult dependent relative. Please read this information and the applicable Benefit Program materials very carefully, because each Benefit Program may define the term “dependent” in a slightly different way.

An employee whose dependent does not qualify for tax-free health coverage will be subject to imputed income on the value of the employer contribution toward health coverage for that dependent. See Section 6, Paying for Coverage, Imputed Income.

Surviving Family Members

For information on eligibility and benefits for surviving family members of certain employees, certain former employees and certain retirees, please see the *LLNS Health & Welfare Benefit Plan for Retirees Summary Plan Description*.

Eligible Adults

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

- your legal spouse as defined under applicable state law; or
- your domestic partner with whom you have a currently valid domestic partnership registration from any state; or
- your adult dependent relative, who was eligible for UC welfare benefits as of December 31, 2003, and who, as of October 1, 2007, is on a list of grandfathered Adult Dependent Relatives provided to LLNS by UC.

In addition to yourself, you may have only *one* eligible adult family member enrolled in your LLNS-sponsored Benefit Programs. For example, if you cover an adult dependent relative on your medical and dental Benefit Programs, you may not also enroll your spouse or registered domestic partner in **any** LLNS-sponsored Benefit Program.

Eligible Children

Children who meet the criteria below are eligible for medical, dental, vision, dependent life, AD&D, and legal benefits. The eligibility rules for children under the LLNS Defined Benefit Eligible Disability Benefit Program and the LLNS Defined Benefit Eligible Survivor Income Benefit Program are different from those set forth here. Please see Appendix B.

Note that your disabled child aged 26 or older is still considered to be your eligible child and not an adult dependent.

You may enroll your registered domestic partner's child even if you do not enroll your domestic partner.

An employee whose dependent does not qualify for tax-free benefit coverage will be subject to imputed income on the value of the employer contribution for that dependent. See Section 6, Paying for Coverage, Imputed Income.

Child	Eligibility	Must meet all applicable requirements
Natural, stepchild, placed for adoption or adopted child, or foster child	To age 26	
Registered domestic partner's child (Domestic partners must have a currently valid domestic partnership registration from any state).	To age 26	▪ unmarried ▪ living with you ▪ supported by you or your registered domestic partner (50%+) ▪ claimed as a tax dependent by you or your registered domestic partner Please note: The above criteria do not apply if your registered domestic partner's child is considered your stepchild under applicable state law.
Legal ward	To age 18	▪ unmarried ▪ living with you ▪ supported by you (50%+) ▪ claimed as your tax dependent
Overage disabled child (except a legal ward) of employee	Age 26 or older	▪ unmarried ▪ living with you if not your natural or adopted child ▪ enrolled in a group medical benefit program before age 26 with continuous coverage ▪ once eligible, continuous coverage under a LLNS group medical benefit program must be maintained for the overage dependent; if coverage is dropped, coverage is no longer available ▪ supported by you (50%+) and claimed as your dependent for income tax purposes or eligible for Social Security income or Supplemental Security Income as a disabled person. The overage disabled child may be working in supported employment which may offset the Social Security or Supplemental Security Income ▪ incapable of self-support due to a mental or physical disability incurred prior to age 26 as determined by the medical carrier ▪ must be approved before age 26 or by the carrier during the Period of Initial Eligibility (PIE) for newly eligible employees

Ineligible Persons

Excluded Workers

Individuals classified by LLNS as independent contractors, supplemental labor or leased employees are not eligible to participate in the Plan.

Any person who is not treated as a common law employee by LLNS for income tax and employment tax withholding purposes, regardless of any subsequent determination of such individual's legal employment status, will not be eligible to participate in the Plan.

Ineligible Family Members

Only eligible family members may participate in the benefits offered under this Plan.

Qualified Medical Child Support Orders (QMCSOs)

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

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

You can get a copy of the Plan's QMCSO procedures upon written request to the Plan Administrator listed in Appendix F at no cost to you.

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

No Duplicate Coverage

Plan rules do not allow duplicate coverage. You may not be covered in LLNS-sponsored coverage at the same time as an employee and as an eligible family member of another LLNS employee or retiree.

In addition, this means you may not be covered at the same time in LLNS-sponsored coverage as an active employee and as a retiree.

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

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

If you were receiving coverage as a retiree, and are rehired as an active employee, you must dis-enroll from your retiree coverage and enroll as an active participant.

Family members of LLNS employees may not be covered by more than one LLNS employee's program coverage, per Benefit Program. For example, if a husband and wife both work for LLNS, the parents must choose which parent will cover their children for which benefit. The children cannot be covered by both employees as family members for medical coverage or any other coverage.

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

For additional information, refer to the applicable Benefit Program material listed in Appendix C.

Misuse of Plan

LLNS reserves the right to dis-enroll individuals and their family members who misuse the Plan, including terminating coverage retroactively where permitted by law. Misuse of the Plan includes, but is not limited to, actions such as

falsifying enrollment or claims information, allowing ineligible individuals to use Plan identification cards, and threats or abusive behavior towards Plan providers or representatives.

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

Documentation

To verify eligibility for your family members, LLNS and the insurance carriers and third-party administrators may request documentation to verify the relationship, including but not limited to birth certificates, adoption records, marriage certificates, verification of domestic partnership registration, proof of adult dependent eligibility and tax documentation. See Section 11, General Plan Provisions, Administration of Plan.

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

It is your responsibility to provide accurate information and to make accurate and truthful statements regarding family status, age, relationships, *etc.*, and to update previously provided information and statements as soon as possible, but no later than 31 days after the relevant event. Failure to do so may be considered an intentional misrepresentation of material fact, and may result in termination of Plan coverage, including a retroactive termination of coverage. At any time, the Plan Administrator may require proof that a person qualifies or continues to qualify as an eligible dependent. Your failure to provide required evidence of eligibility may be considered an intentional misrepresentation of material fact and may, as determined by the Plan Administrator, result in disenrollment of the individual for whom such evidence is requested, including a retroactive disenrollment. In addition, employees may be subject to disciplinary action and may be responsible for benefits paid by the Plan for coverage provided to ineligible individuals.

Loss of Family Member Eligibility

Whenever a family member loses eligibility to participate in LLNS-sponsored Benefit Programs, it is your responsibility to dis-enroll that family member from the Benefit Program within 31 calendar days by submitting a form available from LLNL Benefits Office. If you do not, you are liable for any Benefit Program claims incurred by the ineligible family member.

See Section 9, Continuation of Health Care Coverage for information about COBRA.

3. How to Enroll

Active Employees

If you're a new employee, you will receive an email containing a link to information when you begin work at LLNS. If you do not receive the email please contact LLNL Benefits Office. By electing to participate in one or more Benefit Programs offered under the Plan, you also authorize LLNS to deduct your share of the cost of your coverage from your pay.

Default Enrollment in Core Health Benefits

If you are eligible for medical, dental or vision benefits and you fail to enroll, you will be defaulted into single party Core medical, dental or vision benefits and you must wait until the next Open Enrollment or a PIE to enroll. Your required contributions for this default coverage will be automatically deducted from your paycheck on a pre-tax basis.

Period of Initial Eligibility (PIE)

A Period of Initial Eligibility (PIE) is a time during which you and/or, as applicable, your eligible family members may enroll in certain LLNS-sponsored Benefit Programs.

A PIE starts on the first day of eligibility and ends 31 calendar days later—for example, a PIE starts on the day you are hired into a position that makes you eligible for benefits or the date you are notified in writing that the appointment was effective retroactive.

If the 31st day falls on a weekend or holiday, the PIE will end on the next business day.

Evidence of Insurability (Good Health)

Note that certain benefits may require evidence of insurability (proof of good health) if you do not enroll when initially eligible and wish to enroll at a later date. Please see the applicable Benefit Program materials for more information.

Other Periods of Initial Eligibility

If you are not enrolled in a LLNS-sponsored health and welfare plan, and you have a newly eligible family member, you may be eligible to enroll yourself and your eligible family member(s) at that time.

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

Adopted Child. The PIE for an adopted child begins on the earlier of the date the child is placed in your physical custody or the date you, your spouse, or registered domestic partner has the legal right to control the child's health care. If you do not enroll your child during this PIE, a second PIE begins on the date the adoption is final. Coverage begins on the first day of the PIE in which you enroll the child.

Annual Open Enrollment

If you are a current employee, you may generally enroll for coverage, change your coverage, or waive coverage during the annual open enrollment period. However, certain benefits may not be open to new enrollees every year.

Open enrollment elections are effective January 1 of the following year. If you do not change your elections during open enrollment, your coverage levels will continue from the previous year with the exception of possible rate changes and contributions to the reimbursement accounts, which terminate at the end of each year.

COBRA qualified beneficiaries are eligible to participate in the open enrollment process for their COBRA-covered health benefits if their maximum COBRA period has not expired. (See Section 9. Continuation of Health Care Coverage.

When Coverage Begins

The date coverage begins will depend on when you are enrolled for coverage under a Benefit Program, and the terms of the Benefit Program in which you are enrolled. In general, coverage under the Plan begins the first day of employment. For more information, review the applicable Benefit Program material listed in Appendix B.

If you are not initially eligible on the first day of your employment and later become eligible, coverage will generally be effective on the date of

eligibility as long as you provide notice to the LLNL Benefits Office on the applicable enrollment forms within 31 calendar days of the event which caused you to be eligible.

When Coverage Ends

Active Employees

Active employee coverage generally ends:

- the last day of the month in which you become ineligible for coverage, subject to the Plan's rules for continued coverage during an approved leave of absence (as described later in this SPD),
- the last day of the coverage period for which your required benefit contributions have been paid if the benefit contributions for the next coverage period are not paid when due, or
- the date the Plan or Benefit Program terminates or is amended to exclude the category of employees to which you belong from coverage,

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

Please note that certain of the Plan's Benefit Programs, including life, AD&D, and disability insurance coverage, may end coverage earlier than the dates listed above (for example, on the date you become ineligible for coverage). Please see the applicable Benefit Program material for additional information.

Dependent Care Reimbursement Account (DCRA) coverage ends on the last day of the pay period following the date of termination or the effective date of a leave of absence.

LLNS, in its discretion, may adopt special continued eligibility rules for employees who lose coverage as a result of a furlough or reduction in force.

Dependents of Employees

Coverage for dependents generally ends:

- the last day of the coverage period for which your required benefit contributions have been paid if the benefit contributions for the next coverage period are not paid when due,
- the last day of the month in which your dependent ceases to be eligible for coverage, or
- the date the Plan or Benefit Program terminates or is amended to exclude your dependent from coverage,

and/or as further described in the Benefit Program material, whichever occurs first. Please note that certain of the Plan's Benefit Programs, including life, AD&D, and disability insurance coverage, may end coverage earlier than the dates listed above (for example, on the date your dependent becomes ineligible for coverage). Please see the applicable Benefit Program material for additional information.

COBRA Continuation of Health Coverage

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, you (a LLNS employee) and/or your dependents may be eligible to continue health program coverage (called "COBRA coverage") at group rates. Health Benefit Program coverage includes medical, dental, vision, and Health Care Reimbursement Account (HCRA) benefits and the Employee Assistance Program.

For additional information about COBRA coverage, see Section 9. Continuation of Health Care Coverage.

Dependent Care Reimbursement Account (DCRA) coverage ends on the last day of the pay period following the date of termination or the effective date of a leave of absence. See the DCRA Benefit Program material listed in Appendix B for additional information on the DCRA benefit.

Health Care Reimbursement Account (HCRA) coverage ends on the last day of the month following the date of termination. For leave of absence outside of FMLA or USERRA, it is the pay period end date after the event date. (See the HCRA Benefit Program Summary for details on FMLA or USERRA leaves.) Following termination, HCRA coverage may be extended under COBRA or other continuation coverage. See Section 9. Continuation of Coverage and the HCRA Benefit Program material listed in Appendix B for additional information on COBRA or other continuation coverage.

4. Health Program Information

The Plan includes health (e.g., medical, dental, vision, employee assistance and HCRA) programs.

Benefit Program Material

The Benefit Program material listed in Appendix B for the health program in which you are enrolled generally will be sent to you via e-mail. If you don't receive this material, contact the LLNL Benefits Office.

The Benefit Program material listed in Appendix B describes the nature of covered services including, but not limited to:

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

You may also obtain a copy of the Benefit Program material for the health program in which you are enrolled by contacting the program directly at the address or phone number listed in Appendix C. Or, you may contact the LLNL Benefits Office.

Provider Networks

If you are enrolled in a health program that offers benefits through provider networks, a list of providers is available on the health program's web site, or via the phone number listed in Appendix C.

Refer to the Benefit Program material in Appendix B for your health program for a description of:

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

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

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

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

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

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

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

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

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

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

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

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

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

No Pre-existing Conditions Limitations for Medical Benefits

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

5. Other Benefits Information

Benefit Program Material

This section discusses Benefit Programs other than health benefits. For health benefit information, see Section 4. Health Program Information.

The Benefit Program materials listed in Appendix B for the program in which you are enrolled generally will be sent to you. If you don't receive this material, contact the LLNL Benefits Office.

The Benefit Program material listed in Appendix B describes the nature of covered services including, but not limited to:

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

You may also obtain a copy of the Benefit Program material for the program in which you are enrolled by contacting the program directly at the address or phone number listed in Appendix C. Or, you may contact the LLNL Benefits Office.

Life, Disability, and Accident Benefits

Employees of LLNS are eligible for life, dependent life, accidental death and dismemberment (AD&D), supplemental disability, and business travel accident benefits if they meet the requirements described in Section 2. Eligibility Requirements and in the applicable Benefit Program material listed in Appendix B.

Short-term Disability

Employees who work in California are covered by the state disability program (SDI).

Dependent Life and AD&D

Eligible employees may elect to cover their eligible dependents for certain life and AD&D benefits. In addition to eligibility, the Benefit Program material may describe the coverage, terms, limitations, and costs to you (if applicable).

Supplemental Disability

Note that pre-existing conditions may limit the amount of benefits you can receive under the supplemental disability program. Please see the Supplemental Disability Benefit Program Summary listed in Appendix B for more information.

Evidence of Insurability

Enrolling in or increasing coverage for supplemental and dependent life insurance and supplemental disability insurance outside of a period of initial eligibility (PIE) requires evidence of insurability (proof of good health).

The insurance company may or may not accept your enrollment based on the statement of health.

Special Rules for UC Transitioning Employees

Supplemental Life and Dependent life

A UC Transitioning Employee is eligible to retain his or her supplemental life and dependent life coverage in force as of September 30, 2007, without providing evidence of insurability. However, any increases in coverage and other changes to coverage are subject to all applicable requirements, including evidence of insurability.

Supplemental disability

A UC Transitioning Employee is eligible to retain his or her supplemental disability coverage in force as of September 30, 2007, without providing evidence of insurability. However, increases in coverage and other changes to coverage are subject to all applicable requirements, including evidence of insurability.

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

Supplemental Life – Disability Waiver of Premium

If you are covered under Supplemental Life, become totally disabled (as defined in the applicable Benefit Program material) before age 65, and your disability continues for at least six consecutive months, you may qualify for continuance of life insurance protection without paying the premiums. You must provide written proof of your disability to the insurance carrier no later than one year after disability starts. The carrier will decide whether you qualify for the disability premium waiver. Disability waiver of premium terminates at age 70. For information, contact LLNL Benefits Office.

Continuation of Life Insurance Benefits

When your life insurance coverage ends you may be able to apply to continue your coverage by purchasing an individual conversion policy or a portable policy. For information on your conversion rights and/or your right to elect coverage under a Portability Plan (for Supplemental Employee Term Life and Dependents Term Life Coverages), please refer to the appropriate Benefit Program material listed in Appendix B. You may also check with the life insurance benefit program provider.

Legal Program

The LLNS employee-paid group legal program provides basic legal services for eligible employees and their eligible family members. Enrollment in the legal program is limited to newly eligible employees during their PIE or during open enrollment periods in which the legal program is offered. For more information, review the Benefit Program material listed in Appendix B.

Reimbursement Accounts

Health Care Reimbursement Account (HCRA)

The Health Care Reimbursement Account (HCRA) allows you to set aside money on a pre-tax basis to help pay for certain health care (medical, dental and vision) expenses. This means you pay no taxes on the amount you contribute to your HCRA account. You draw on this account to reimburse yourself for eligible health care expenses.

Eligible expenses generally are those for which you could take a health care expense deduction on your federal income tax return, such as health program deductibles, co-payments, and out-of-pocket expenses for medical services not covered at 100%. However, insurance premiums and expenses for long term care are *not* reimbursable expenses under the HCRA. If you are eligible for the HSA, you are not eligible for the HCRA.

For additional information on the benefits and terms for the HCRA, including the rules related to FMLA leave, please refer to the Health Care Reimbursement Account program material listed in Appendix B.

Dependent Care Reimbursement Account (DCRA)

The Dependent Care Reimbursement Account (DCRA) allows you to set aside money on a pre-tax basis to help pay for certain dependent care expenses necessary to allow you and your spouse, if any, to work or look for work.

This means you pay no taxes on the amount you contribute to your DCRA account. You may draw on this account to reimburse yourself for eligible dependent care expenses you incur for your eligible dependents, such as your child under age 13, or a spouse or other dependent of any age who is physically or mentally unable to care for himself or herself and satisfies certain other requirements.

For additional information on the benefits and terms under DCRA, please refer to the Dependent Care Reimbursement Account Benefit Program material listed in Appendix B.

Important Note

In addition to DCRA, another method of tax savings for dependent care expenses is the federal child and dependent care tax credit. Depending on your personal situation, you may be able to participate in DCRA for certain expenses, and still take a federal tax credit for certain remaining eligible expenses. However, you may not take both the federal tax credit *and* receive reimbursement from DCRA for the same expenses. You may want to consult IRS Publication 503 and/or a tax advisor to help you decide whether the federal tax credit and/or DCRA will result in better tax savings for you.

Health Savings Account

The Health Savings Account (HSA) allows you to set aside money on a pre-tax basis to help pay for certain health care (medical, dental and vision) expenses. This means you pay no taxes on the amount you contribute to your HSA account. You draw on this account to reimburse yourself for eligible health care expenses.

Eligible expenses generally are those for which you could take a health care expense deduction on your federal income tax return, such as health program deductibles, co-payments, and out-of-pocket expenses for medical services not covered at 100%.

The HSA is available with certain medical plans. For additional information on the benefits and terms for the HSA, please refer to the Anthem Blue Cross and Kaiser program material listed in Appendix B**.** If you are eligible for the HSA, you are not eligible for the HCRA.

Making Changes to Your Reimbursement Account Plan Elections

Qualified Life Event Changes

Once you make your elections for participation in either Reimbursement Account, you generally may not change your elections until the next annual open enrollment period. However, certain changes are permitted if you meet the criteria described in Section 7. Making Changes to Your Elections.

Severance Program

For information about the LLNS Severance Program review the Benefit Program material listed in Appendix B**.**

LLNS Defined Benefit Eligible Disability Program

For information about the LLNS Defined Benefit Disability Program, review the Benefit Program material listed in Appendix B.

LLNS Defined Benefit Eligible Survivor Income Program

For information about the LLNS Defined Benefit Eligible Survivor Income Program, review the Benefit Program material listed in Appendix B**.**

6. Paying for Coverage

You and LLNS share the cost of coverage under certain Benefit Programs, as described in Appendix A. Your portion of the cost varies according to your benefits and coverage levels (i.e., single, family, etc.). For more information, refer to Appendix A.

The cost of coverage does not include your costs for any applicable deductibles, co-payments, out-of-network charges, or non-covered items.

Employee Contributions for Health Benefits

Pre-Tax Employee Contributions

Active employees automatically pay their contributions for health benefits (includes medical, dental, and vision) on a "pre-tax" basis.

In addition, contributions to the Health Care Reimbursement Account (HCRA), the Dependent Care Reimbursement Account (DCRA), and the Health Savings Account (HSA) are made on a pre-tax basis.

Paying for benefits on a pre-tax basis reduces your gross salary, which lowers your taxable income and, therefore, the amount of federal tax, and generally most state taxes, you must pay.

Paying for benefits on a pre-tax basis means that Social Security taxes will not be deducted for the pre-tax contribution. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these payments. This could result in a small reduction in the Social Security benefit you receive at retirement. Please consult your tax advisor for additional information on how participation in HCRA, DCRA, and the HSA may affect you.

LLNS Contributions for Health Benefits

LLNS contributions for health benefits are generally not taxable income to employees.

Imputed Income

Imputed income means the value of any benefit or service that must be considered income for the purposes of calculating your federal taxes. For example, the value of employer-paid life insurance in excess of $50,000, and LLNS contributions for coverage for any individual who is not either your child (natural, stepchild, placed for adoption, adopted, or foster) to age 26 or your dependent for tax purposes will result in imputed income to you.

For example, to receive tax favored health benefits, your registered domestic partner must qualify as your dependent for tax purposes. It is your responsibility to submit proof to the Plan that your registered domestic partner or your registered domestic partner's child qualifies as a tax dependent. Special rules apply for divorced parents.

Please contact the LLNL Benefits Office if you have questions regarding domestic partner or other eligibility.

You may also see IRS Publication 502 for a discussion of the definition of a tax dependent. The publication is available at www.irs.gov/Forms-&-Pubs. You may also wish to consult your tax advisor for additional information.

Changes to Coverage and Contributions

Premiums are paid in the current month by payroll deduction or salary reduction based on the 15th of the month rule. If a benefit change or a new benefit has an effective date from the 1st to the 15th of the month, the employee is required to pay for the full month. If a benefit change or a new benefit has an effective date that occurs from the 16th to the end of the month, the employee does not owe premiums for that month. This does not apply to open enrollment or other permitted transfers between Benefit Programs or when an employee re-enrolls during a PIE provided there has been a lapse in coverage of more than one month.

When an employee terminates coverage in a Benefit Program, a family member is deleted, or a transfer between Benefit Programs is made, any premium adjustment is made based on the 15th of the month rule.

Employee Contributions for Other Benefits

Employee contributions for Basic, Core, Supplemental and Dependent Life, Supplemental

Disability, Legal, and AD&D insurance are paid on an after-tax basis.

Unpaid Leave of Absence

Employees who are on unpaid leaves of absence and eligible to continue coverage must pay for coverage on an after-tax basis through direct billing.

Please contact the LLNL Payroll Office to make arrangements to pay premiums during an unpaid leave of absence.

LLNL Payroll Office

Mailing Address
P.O. Box 808, L-435
Livermore, CA 94551

Street Address
7000 East Ave., L-435
Livermore, CA 94550

Telephone 925-424-4444
Fax 925-424-2663

Health Care Benefits During Family Medical Leave Act (FMLA), California Family Rights Act (CFRA) and Pregnancy Disability Leave Act Leave

LLNS contributions for your health care benefits (medical, dental, vision, EAP) will continue during an approved leave without pay under the provisions of the FMLA and/or CFRA for up to 12 workweeks (or 26 workweeks for military caregiver FMLA leave) for the employee and any enrolled family members, provided the employee was enrolled in the respective Benefit Program at the beginning of the leave. LLNS contributions for your health care benefits will also continue during an approved leave without pay under the provisions of the Pregnancy Disability Leave Act for up to 4 months. You may also continue your benefits under the Health Care Reimbursement Account during an approved leave under the FMLA, CFRA, or Pregnancy Disability Leave Act.

If you are receiving pay during an FMLA/CFRA leave or Pregnancy Disability Leave Act leave, your contribution, if any, for medical, dental, vision, and the Health Care Reimbursement Account will continue to be deducted from your pay. If you are not receiving pay during an FMLA/CFRA or Pregnancy Disability Leave Act leave, you must "pay as you go" on an after-tax basis through direct billing.

You may also revoke your health coverage elections and not have coverage during FMLA, CFRA or Pregnancy Disability Leave Act leave. In this case, when you return to work after the leave, you can be reinstated in the same benefits you had before your leave unless an intervening Life Event or open enrollment occurs during your FMLA/CFRA or Pregnancy Disability Leave Act leave in which case you may be able to change your benefit elections.

For additional information on FMLA, CFRA and Pregnancy Disability Leave Act leaves, such as how to request a leave and other rights and obligations, as well as their impact on Plan benefits, please contact the LLNL Benefits Office.

Short Term Disability and Other Approved Leave

For employees who become eligible for disability benefits or are otherwise on an approved leave of absence (including an approved leave period that extends beyond the leave period provided by the FMLA, CFRA, or Pregnancy Disability Leave Act), LLNS will continue medical, dental, and vision plan contributions and EAP and Health Care Reimbursement Account coverage for up to six months provided their LLNS employment is not terminated.

Employees must arrange direct payment of any net premiums and Health Care Reimbursement Account contributions through the LLNL Payroll Office at the above location.

Payment must be made generally during the last week of the current billing month.

The employee may not continue to cover a family member who loses eligibility. The employee must delete the family member from the plan within 31 calendar days of ineligibility.

Employees may remain enrolled in the LLNS group health benefit programs for up to two years during an approved leave of absence, but will be responsible for the full cost of coverage (both the employer and employee share) after the first six months of approved leave.

For more information on leaves of absence, refer to the LLNS Human Resources Personnel Policies Manual, Time Away from Work. You may also contact the Benefits Office at 1-925-422-9955 and ask to speak with a Leave Management Specialist.

Other Benefits During an Approved Leave

Dependent Care Reimbursement Account coverage ends on the date your approved leave of absence begins. You may re-enroll within 31 days of returning to work. Coverage under all other non-group health benefit programs during a leave of absence may be continued in accordance with the terms of the applicable Benefit Program materials. For more information, please review the Benefit Program materials listed in Appendix B and refer to the LLNS Human Resources Personnel Policies Manual, Time Away from Work. You may also contact the Benefits Office at 1-925-422-9955 and ask to speak with a Leave Management Specialist.

7. Making Changes to Your Elections

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

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

You must contact the LLNL Benefits Office within 31 calendar days of the event to request this change. Otherwise, your next opportunity to enroll new dependents or make other Benefit Program changes is generally the next annual open enrollment period or the date you have another qualified Life Event (or other applicable event) whichever occurs first.

Life Events

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

- **Legal marital status.** An event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, or annulment.
- **Domestic partnership status**. An event that changes the status of your domestic partnership registration, including establishment or termination of a domestic partnership or death of your domestic partner. Note: See "Special Note Regarding Domestic Partner Coverage," below, for additional information regarding changes relating to coverage for a registered domestic partner or a registered domestic partner's child.
- **Number of dependents.** An event that changes your number of dependents, including birth, death, adoption, and placement for adoption.
- **Employment status.** An event that changes your, your spouse's or your other dependent's employment status that results in gaining or losing eligibility for coverage. Examples include:
  - Beginning or terminating employment
  - Starting or returning from an unpaid leave of absence
  - A change in your appointment status that results in a change in the level of benefits for which you are eligible (See Section 2, Eligibility Requirements.)
- **Dependent status.** An event that causes your dependent to become eligible or ineligible for coverage because of age or other circumstances.
- **Residence.** A change in the place of residence of you, your spouse or another dependent which results in a loss of eligibility.

Consistency Requirements

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

- **Effect on eligibility.** Except for the DCRA, the Life Event must affect eligibility for coverage under the Plan or under a plan sponsored by the employer of your spouse or other dependent. For this purpose, eligibility for coverage is affected if you become eligible (or ineligible) for coverage or if the Life Event results in an increase or decrease in the number of your dependents who may benefit from coverage under the Plan.

  For the DCRA, the Life Event must affect the amount of dependent care expenses eligible for reimbursement. (For example, your child reaches age 13, and dependent care expenses are no longer eligible for reimbursement.)
- **Corresponding election change.** The election change must correspond with the Life Event. For example, if your dependent loses eligibility for coverage under the terms of a health program due to age, you may cancel health coverage only for that dependent.

For life insurance and disability insurance coverages, an election to increase or decrease coverage in response to a Life Event is considered to correspond with the event. Election changes for the life, AD&D, and disability coverages are only permitted to the extent permitted by the terms of the applicable Benefit Program materials.

You must contact the LLNL Benefits Office within 31 calendar days of the event.

Otherwise, your next opportunity to make changes will be the next open enrollment period or PIE, whichever occurs first.

Coverage and Cost Events

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

You are not permitted to make a change to your HCRA due to coverage and cost events. For additional information changing HCRA elections, please refer to the Health Care Reimbursement Account benefit program material listed in Appendix B.

Coverage Events

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

Here are some examples:

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

Cost Events

If your cost for health program coverage increases or decreases significantly (as determined by the Plan Administrator) during the Plan year, you may make a corresponding election change. In addition, if there is a significant decrease in the cost of a Benefit Program during the Plan year, you may enroll in that Benefit Program, even if you declined to enroll in that Benefit Program earlier.

Changes in the cost of your Benefit Program that are *not* significant will result in an automatic increase or decrease, as applicable, in your share of the total cost.

Dependent Care Reimbursement Account

If you change your dependent care provider mid-year, you may change your DCRA contributions to correspond with the new provider's charges. Similarly, if your dependent care provider (other than a provider who is your relative) raises or lowers its rates mid-year, you may increase or decrease your contributions.

If your dependent care provider reduces or increases the number of hours of care it provides, you may make a corresponding change to your DCRA election.

You must contact the LLNL Benefits Office within 31 calendar days of an event. Otherwise, your next opportunity to make changes will be the next open enrollment period or when you have another Life Event or other applicable event, whichever occurs first.

For additional information changing DCRA elections, please refer to the Dependent Care Reimbursement Account program material listed in Appendix B.

Special Enrollment Rights – Medical Coverage

If you decline enrollment for medical coverage for yourself or your dependents (including your spouse) because of other health plan coverage, you may in the future be able to enroll yourself and your dependents in such coverage under the Plan, if you or your dependents lose other coverage or you gain a new dependent as described below.

Loss of other coverage. This rule applies if you meet both of the following conditions:

- You (or your dependents) were covered under other health coverage (for example, under another employer's medical plan) when LLNS coverage was previously offered to you; and
- You (or your dependents) lose other coverage because:
  - You or your dependents exhaust rights to COBRA coverage, or
  - The employer's contributions to the other coverage stop, or
  - You or your dependents are no longer eligible under that plan. A "loss of eligibility" for coverage does not include a loss due to a failure to timely pay premiums or termination of coverage for cause. A special enrollment right may arise if you lose eligibility for other health plan coverage because of legal separation; divorce; cessation of dependent status; death of an employee; termination of employment; reduction in the hours of employment; ceasing to reside, live or work in the service area of an HMO if the other coverage was provided through that HMO; or the other plan ceasing to offer any benefits to the class of similarly situated individuals that includes you or your dependent as applicable.

If you or your dependent loses other health coverage due to one of these conditions, you may change health plan options or enroll yourself and your eligible dependents in a LLNS health plan within 31 calendar days of the loss of coverage.

Acquiring new dependents. When you acquire a newly eligible dependent spouse or child (through marriage, birth, adoption, or placement for adoption), you may change health plan options or enroll yourself, your spouse, and eligible dependent children in a LLNS health plan within 31 calendar days of the date you acquire the new dependent.

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

Loss of eligibility under Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or your eligible dependents while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may enroll yourself and your eligible dependents in the Plan's medical coverage if you or your eligible dependents lose eligibility for that other coverage.

You must request enrollment within 60 days after coverage ends under Medicaid or a state children's health insurance program.

Eligibility for premium assistance through Medicaid or a State Children's Health Insurance Program. If you or your eligible dependents become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program, you may enroll yourself and your eligible dependents in the Plan's medical coverage. You must request enrollment within 60 days after you or your eligible dependent becomes eligible for such assistance.

Rehire after Termination

An employee who loses coverage as a result of termination and who returns to work within 30 days will be reinstated into the same benefits and coverage levels in effect on the date of loss of coverage. An employee who returns to work or

has coverage reinstated after 30 days of the loss of coverage, will receive a new PIE.

Furlough, reduction in force, insufficient earnings or hours

An employee who loses coverage as a result of unpaid leave of absence, furlough, reduction in force, or insufficient earnings will be reinstated into the same benefits and coverage levels in effect on the date coverage was lost, upon meeting eligibility requirements. An employee who loses coverages as a result of hours falling below the minimum of 17.5 hours per week will become eligible again when he/she receives a new appointment that qualifies for benefits, at which time they will be eligible to make new benefit elections.

Other Rules on Changing Coverage

Medicare or Medicaid Entitlement. You may, but are not required to, change an election for medical coverage mid-year if you, your spouse, or dependent becomes entitled to Medicare or Medicaid coverage. However, you're limited to reducing your coverage only for the person who becomes entitled to Medicare or Medicaid, and you're limited to adding coverage only for the person who loses eligibility for Medicare. Please see the Special Enrollment Rights section above for additional information about your enrollment rights under the Plan if you lose eligibility for Medicaid coverage.

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP (Children's Health Insurance Program) programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. CHIP contact information for the State you live in is available from the Benefits Office. Please also see the Special Enrollment Rights section above for additional information about your enrollment rights under the Plan if you become eligible for premium assistance through Medicaid or a State CHIP program.

Family and Medical Leave Act and California Family Rights Act You may revoke an election for health coverage mid-year (including the HCRA) when you begin a leave, subject to the provisions of the Family and Medical Leave Act (FMLA) and/or the California Family Rights Act (CFRA).

If you revoke coverage or if you fail to make payments during your FMLA/CFRA leave, when you return from the FMLA/CFRA leave, you generally will be reinstated to the same elections you made prior to taking your /CFRA leave. However, refer to the HCRA/DCRA Benefit Program Summary referenced in Appendix B for more information about HCRA and FMLA/CFRA leave.

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

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

Special Note Regarding Domestic Partner Coverage

The events qualifying you to make a mid-year election change described in this section also apply to events related to a dependent who is your registered domestic partner or your registered domestic partner's child.

More Life Event Information

Detailed information about Life Events and PIEs may be obtained from the LLNL Benefits Office.

8. Claims and Appeals Procedures

Important Note

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

Any claim or appeal for a specific benefit shall be made in accordance with the applicable Benefit Program material directly to the Claims Administrator for that specific benefit. See Appendix C for Claims Administrators.

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

A claim for benefits must be filed within twelve (12) months from the date the claim was incurred or as provided in the applicable Benefit Program material. A claim is incurred for this purpose when the individual is provided with the service that gives rise to the expense, not when the individual is billed or charged for the service.

No action at law or in equity in any court or agency legal action shall be brought to recover benefits under the Plan prior to the exhaustion of the applicable (mandatory) ERISA Claim and Appeal Procedures. If the benefits are provided under an insurance policy, a claimant must file a legal action pertaining to a claim for benefits under the insurance policy within the time limit prescribed in the applicable insurance policy. For all other claims arising out of or related to the Plan, no legal action may be brought in court or any other judicial forum unless it is brought by the earliest of the following dates:

(a) One year from the date a final adverse benefit determination is made under the Plan or should have been made in accordance with the Benefit Program's claims and appeals procedures;

(b) One year from the date on which the claimant is deemed to have exhausted the Benefit Program's claims and appeals procedures under applicable federal law; or

(c) Two years from the date the service or treatment was provided or the date the claim arose, whichever is earlier.

A claimant's failure to timely file a legal action before expiration of these deadlines will bar any legal action/lawsuit.

Any action related to or arising out of or in connection with the Plan may only be brought or filed in the United States District Court, Northern District of California or, if the District Court declines or lacks jurisdiction, in the Superior Court of California for Alameda County.

The claims procedures for each specific Benefit Program will be furnished automatically to you without charge. See Appendix B. If you do not receive the claims procedures please contact the LLNL Benefits Office.

Health Benefit Claims and Appeals Procedures

Filing an Initial Claim

You must follow the claims procedures established by the various health Benefit Programs (medical, dental, vision, employee assistance program (EAP), and Health Care Reimbursement Account (HCRA)). If you are required to file an initial claim for benefits, you must do so within the time specified by the Benefit Program and in accordance with the Benefit Program's established claim procedures. See the applicable Benefit Program material listed in Appendix B for details on filing claims. See Appendix C for a list of Claim Administrators and their contact information.

Appeals Procedures

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

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

Note: Claims for HCRA benefits are always considered Post-Service Claims.

Definitions

- **Claim.** Any request for program benefits made to the proper person in accordance with the program's claims filing procedures, including any request for a service that must be pre-approved. Claims must be submitted in writing to the appropriate Claims Administrator listed in Appendix C.
- **Urgent Care Claim.** Any claim for health care or treatment that has to be decided more quickly because the normal timeframes for decision-making could seriously jeopardize your life or health or your ability to regain maximum function, or in the opinion of a physician with knowledge of your condition, subject you to severe pain that can't be adequately managed without the care or treatment addressed in the claim.
- **Pre-Service Claim.** Any claim for a health benefit – other than an Urgent Care Claim – that must be approved in advance of receiving medical care (for example, requests to pre-certify a hospital stay or for pre-approval under a utilization review program).
- **Post-Service Claim.** Any other type of health claim, including a claim for reimbursement through the Health Care Reimbursement Account.
- **Concurrent Care Decision.** Any decision in which the program – after having previously approved an ongoing course of medical treatment provided over a period of time or a specific number of treatments – subsequently reduces or terminates coverage for the treatments (other than by program amendment or termination).
- **Adverse Decision or Adverse Decision on Appeal.** A denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a benefit. An adverse decision includes a decision to deny benefits based on: (i) an individual's being ineligible to participate in the program; (ii) utilization review; (iii) a service being characterized as experimental or investigational or not medically necessary or appropriate; and (iv) a concurrent care decision. A rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at that time) is also treated as an adverse benefit determination.
- **Authorized Representative.** An individual authorized to act on your behalf in pursuing a claim or appeal under the Plan's administrative claim and appeal procedures in accordance with procedures established by the program. For Urgent Care Claims, a health care professional with knowledge of your medical condition may act as your authorized representative. (A health care professional is a physician or other health care professional who is licensed, accredited, or certified to perform specified health services consistent with state law.) For information about appointing an authorized representative, contact the Claims Administrator listed in Appendix C.
- **Assignments Prohibited.** No benefit under the self-funded Benefit Programs shall be subject to alienation, sale, transfer, assignment, pledge, or encumbrance or charge, voluntary or involuntary, by operation of law or otherwise, and any attempt at such transactions shall be void. You may not assign your rights, benefits, or any other interest under a self-funded Benefit Program to a healthcare provider or any other individual or entity. The applicable Claims Administrator may, however, in its discretion, pay a healthcare provider directly for services rendered to you or your eligible dependents. The payment of benefits directly to a healthcare provider, if any, will be done as a convenience to you and your eligible dependents and will not constitute an assignment of rights, benefits, or any other interest under the Plan or a waiver of this anti-assignment provision.

Insufficient Claims

Improperly Filed Pre-Service Claim. If a Pre-Service Claim is not filed in accordance with the program's claim procedures, you will be notified as soon as possible, but no later than five days after it is received by the program. If the claim is an urgent care case, you will be notified within 24 hours. Notice of an improperly filed Pre-Service Claim may be provided orally – or in writing, if you

request. The notice will identify the proper procedures to be followed in filing the claim.

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

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

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

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

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

Notice of Benefit Determination

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

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

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

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

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

For Pre-Service and Post-Service Claims, the Claims Administrator may extend the timeframe for making a decision on your claim in certain cases. If an extension is necessary, you will be notified before the end of the initial timeframe (15

days for pre-service claims; 30 days for post-service claims) of the reasons for the delay and when the Claims Administrator expects to make a decision. Further, if an extension is necessary because certain information was not submitted with the claim, the notice will describe the required information that is missing, and you will be given an additional period of at least 45 days after you receive the notice to furnish the information. The Claims Administrator's extension period will begin when the notification of extension is sent and end when you respond to the request for additional information or your time for doing so expires, whichever occurs first. The Claims Administrator will then notify you of the benefit determination within the extended time period specified in the extension notice.

Appeal of Adverse Decision

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

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

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

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

For Claims under the medical Benefit Program, if the Claims Administrator has considered, relied upon, or generated any new or additional evidence in deciding the claim, you will be provided with such evidence sufficiently in advance of the Plan's due date for deciding the appeal so that you have an opportunity to respond to the additional evidence. In addition, before issuing a decision on your appeal that is based on a rationale that was not included in the initial decision, the Claims Administrator for the medical Benefit Program will provide you, free of charge, with the rationale as soon as possible and sufficiently in advance of the appeal decision to give you a reasonable opportunity to respond.

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

Notice of Decision on Appeal

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

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

- **Urgent Care Appeals.** As soon as possible considering the medical urgency, but not later than 72 hours after the Claims Administrator receives your appeal.
- **Pre-Service Appeals.** Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after the Claims Administrator receives your appeal.
- **Post-Service Appeals.** Within a reasonable period of time appropriate to the medical circumstances, but not later than 60 days after the Claims Administrator receives your appeal.

Your Right to Information

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

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

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

External Review

Certain claims brought under the Plan's medical Benefit Program may also be eligible for external review after the Plan's internal appeal procedures have been exhausted. Please see the applicable Benefit Program material listed in Appendix B for details on the external review procedures for the medical Benefit Program.

Non-Health Benefit Claims and Appeals Procedures

Filing an Initial Claim

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

Appeals Procedures

Definitions

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

Notice of Adverse Decision

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

- **For the Disability programs**, the notice of adverse decision will be provided within 45 days after the date your claim is first filed with the Claims Administrator. If more time is needed by the Claims Administrator to make a decision, you will be notified of the reasons for the delay before the end of the 45-day period. The Claims Administrator may extend the decision-making period for up to 30 days. If additional time is needed, the Claims Administrator may extend the decision-making period for an additional 30 days. You will be notified of the second extension before the end of the first extension period. The notice of extension may include a request for additional information from you. You must provide the requested information to the Claims Administrator within 45 days. The Claims Administrator's time for making the benefit determination will be tolled until you respond to the request for additional information or the time period for doing so expires, whichever occurs first.
- **For the Life, AD&D, Legal, Severance, and Survivor Income Benefits programs,** the notice of adverse decision will be provided within 90 days after the date your claim is first filed with the Claims Administrator. If more time is needed by the Claims Administrator to make a decision, you will be notified of the reasons for the delay before the end of the initial 90-day period. The Claims Administrator may extend the decision-making period for up to 90 days if the program's Claims Administrator determines that special circumstances require an extension.

Appeal of Adverse Decision

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

- **For the Disability programs**, the appeal must be filed within 180 days after you receive the notice of adverse decision.
- **For the Life, AD&D, Legal, Severance, and Survivor Income Benefits programs**, the appeal must be filed within 60 days after you receive the notice of adverse decision.

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

For the Disability programs, a new decision-maker will reconsider your claim. The individual who denied the initial claim will not conduct the appeal. The new decision-maker will not give any deference to the original decision on your claim. That is, the reviewer will give the claim a "fresh look" and make an independent decision about the claim.

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

For all non-health program claims, the decision will consider all comments, documentation, and records and other information you submit, even if they were not submitted or considered during the initial claim decision.

Notice of Decision on Appeal

- **For the Disability programs**, the Claims Administrator will provide notice of its decision within 45 days after the date you file the appeal with the Claims Administrator. The Claims Administrator may extend the decision-making period for up to 45 days if special circumstances require extra time. You will be notified of the extension prior to the end of the first 45-day period.

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

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

Your Right to Information

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

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

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

If your claim or appeal is denied based on a determination involving a medical judgment, you are entitled to an explanation of the scientific or clinical reasons for that determination free of

charge upon request. (A medical judgment includes whether a treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate.)

Section 12. Your Rights and Privileges Under ERISA provides additional information on legal action you can take if you feel your right to a benefit has been improperly denied.

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

If you have an issue or dispute regarding the Plan that is not considered a "claim" for benefits under ERISA (e.g., eligibility for Plan benefits or COBRA or the applicability of the Plan's right of reimbursement or subrogation), you must notify the LLNL Benefits office in writing within 90 days of the date on which the action complained of occurred and explain your issue or dispute. You must provide LLNS with any information you think supports your position and any other information LLNS determines is necessary to decide your issue or dispute.

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

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

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

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

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

No action at law or in equity in any court or agency legal action shall be brought to recover benefits under the Plan prior to the exhaustion of the

applicable (mandatory) ERISA Claim and Appeal Procedures.

If the benefits are provided under an insurance policy, a claimant must file a legal action pertaining to a claim for benefits under the insurance policy within the time limit prescribed in the applicable insurance policy. For all other claims arising out of or related to the Plan, no legal action may be brought in court or any other judicial forum unless it is brought by the earliest of the following dates:

(a) One year from the date a final adverse benefit determination is made under the Plan or should have been made in accordance with the Benefit Program's claims and appeals procedures;

(b) One year from the date on which the claimant is deemed to have exhausted the Benefit Program's claims and appeals procedures under applicable federal law; or

(c) Two years from the date the service or treatment was provided or the date the claim arose, whichever is earlier.

A claimant's failure to timely file a legal action before expiration of these deadlines will bar any legal action/lawsuit.

Any action related to or arising out of or in connection with the Plan may only be brought or filed in the United States District Court, Northern District of California or, if the District Court declines or lacks jurisdiction, in the Superior Court of California for Alameda County.

9. Continuation of Health Care Coverage

Federal COBRA Continuation Coverage

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, you (a LLNS employee) and/or your dependents may be eligible to continue health program coverage (called "COBRA coverage") at group rates. Health benefit program coverage includes medical, dental, vision, employee assistance and Health Care Reimbursement Account (HCRA) benefits.

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

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

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

Cost of COBRA Coverage

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

The cost of health benefit program coverage periodically changes. If you elect COBRA coverage, the COBRA Administrator will notify you of any changes in the cost. Premiums are established in a 12-month determination period and will increase during that period if the Plan has been charging less than the maximum permissible amount, if the qualified beneficiary changes coverage level, or in the case of a disability extension.

The initial payment for COBRA coverage is due 45 days from the date of your election. Thereafter, you must pay for coverage on a monthly basis. You have a grace period of 30 days for all premiums after your initial premium payment for COBRA coverage.

COBRA Administrator

The Plan Administrator has delegated certain COBRA administration duties to the LLNL Benefits Office and to outside health care vendors.

Consequently, your COBRA information will come from the health care vendors listed in Appendix E.

Contact the LLNL Benefits Office:

- To notify of an initial COBRA qualifying event, or
- If you have general questions about COBRA coverage.

If you or a family member elect COBRA, and subsequently have questions about COBRA billing, please contact the vendor directly as listed in Appendix E.

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

Keep Your Records Updated

Before you or your dependent elect COBRA, make sure that LLNS has you and your dependents' current home address and telephone number.

Lawrence Livermore National Lab
Attn: LAPIS
P.O. Box 808, L-631
Livermore, CA 94550
Telephone: 925-422-2444
https://lapis-int.llnl.gov/

After you or your dependents elect COBRA, make sure that the health benefit program always has your current home address and telephone number. Send your information to the benefit program(s) listed in Appendix E or as directed in the materials provided by the health benefit program providing your COBRA coverage.

Who is Eligible for COBRA

If you're covered by a health benefit program on the day before a qualifying event, you have the right to choose COBRA coverage if you lose coverage under the terms of the health benefit program because of a reduction in your hours of employment or the termination of your employment (unless you're terminated because of your gross misconduct).

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

- your spouse dies;
- your spouse's employment is terminated (for reasons other than gross misconduct) or your spouse's hours of employment are reduced; or
- you divorce or legally separate from your spouse (this includes a divorce or legal separation that occurs after the employee drops you from coverage, if the employee acted in anticipation of the divorce or legal separation).

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

- the employee dies;
- the employee's employment is terminated (for reasons other than the employee's gross misconduct) or the employee's hours of employment are reduced; or
- you cease to be a "dependent child" under the health benefit program.

If the covered employee elect's continuation coverage and then has a child (either by birth, adoption or placement for adoption) during that period of COBRA coverage, the new child is a qualified beneficiary.

In accordance with the terms of the health benefit program and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage by providing a written notice to the health benefit program of the new child's birth, adoption or placement for adoption at the address listed in Appendix E or as directed in the materials provided by your health benefit program.

This written notice should include information about the new child who will be receiving COBRA coverage. The health benefit program may ask for documentation supporting the birth, adoption or placement for adoption of the new child.

If a qualified beneficiary fails to notify the health benefit program about such new child within 31 calendar days of the birth, adoption or placement for adoption COBRA coverage cannot be elected for the new child. Newly acquired eligible dependents (such as a spouse) won't be considered qualified beneficiaries, but may be added as dependents. Notify the health benefit program within 31 calendar days if you acquire a new spouse and want to enroll your new spouse in COBRA coverage.

Continuation Coverage for Domestic Partners

Although registered domestic partners are not "qualified beneficiaries" under federal COBRA, LLNS currently provides continuation coverage to domestic partners who were covered under the health benefit programs when group coverage would otherwise have been lost. In the description of federal COBRA above:

- Wherever the term "spouse" is used and wherever "qualified beneficiary" when referring to a spouse is used, the term "registered domestic partner" as defined by the Plan also generally applies.
- Wherever the terms "dependent child" or "dependent children" are used, or wherever "qualified beneficiary (ies)" when referring to a

dependent child or dependent children is used, the dependent child/children of a domestic partner also generally applies.

- Wherever the term “divorce” is used, termination of domestic partnership also generally applies.
- Wherever the term “COBRA continuation coverage" is used, continuation coverage also generally applies.

Your Duties to Notify LLNL Benefits Office of a COBRA Qualifying Event

You or your dependent must inform the LLNL Benefits Office of a divorce, legal separation, termination of domestic partnership, or child’s loss of dependent status under the health benefit program in writing if you wish to preserve your dependent’s right to elect COBRA coverage.

You must provide notice within 60 days from the latest of (1) the date of the divorce, legal separation, termination of domestic partnership, or loss of dependent status, or (2) the date coverage is lost because of the event.

Notice must be provided to the LLNL Benefits Office. You may use a form which can be obtained from the LLNL Benefits Office.

The notice must identify the employee or qualified beneficiary requesting COBRA coverage and the qualifying event that gave rise to the individual’s right to COBRA coverage. In addition, the employee or qualified beneficiary may be required to provide the LLNL Benefits Office and/or the health benefit program with documentation supporting the occurrence of the qualifying event.

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

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

COBRA Administrator’s Duties

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

- the employee dies; or
- the employee’s employment is terminated (for reasons other than the employee’s gross misconduct) or the employee’s hours of employment are reduced.

In addition, if you have provided timely written notice of divorce, legal separation, termination of domestic partnership, or child’s loss of dependent status as set forth in “Your duties to notify LLNL Benefits Office of a COBRA qualifying event,” above, the COBRA Administrator will notify the qualified beneficiaries of the right to elect COBRA coverage as a result of:

- divorce;
- legal separation;
- termination of domestic partnership; or
- child’s loss of dependent status.

Electing COBRA

To elect or inquire about COBRA coverage, contact the LLNL Benefits Office.

Under the law, you have 60 days to elect COBRA coverage measured from the date you would lose your active coverage because of one of the events described earlier, or, if later, 60 days after you receive notice of your right to elect COBRA coverage. An employee or family member who doesn’t choose COBRA coverage within the time period described above loses the right to elect COBRA coverage. To the extent permitted by law, the employee and family members will be required to reimburse the Plan for any claims mistakenly paid after the date coverage would normally have ended.

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

You’ll have the same opportunity to change health benefit program coverage as similarly situated active employees have, e.g., at annual open enrollment or if you gain a new dependent.

This also means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified. Your COBRA rights are provided as required by law. If the law changes, your rights will change accordingly.

Separate Elections

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

Length of COBRA Coverage

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

The maximum duration of COBRA coverage depends on the reason you or your covered dependents are eligible for COBRA coverage. If group health coverage ends because of your termination of employment or reduction in hours, COBRA coverage may continue for you and your covered spouse and dependents for up to 18 months.

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

- you die;
- you divorce or legally separate; or
- your dependent child loses eligibility for coverage.

Note that COBRA coverage for the HCRA ends at the end of the Plan year in which the qualifying event occurs. Please also note that COBRA coverage for the HCRA is only available if, at the time of your qualifying event, the premium you must pay for the coverage exceeds the remaining coverage available to you for the Plan year. If you are eligible for and elect to continue your participation in the HCRA, you will be required to pay for the coverage on an after-tax basis (plus the two percent administrative fee).

COBRA disability extension request

The 18 months of COBRA coverage may be extended to 29 months if an employee or covered family member is disabled (as determined by the Social Security Administration) at any time during the first 60 days of an 18-month COBRA coverage period. This 11-month extension is available to all family members who have elected COBRA coverage due to the termination of employment or reduction in hours. It also applies to family members who aren't disabled.

To benefit from the extension, the qualified beneficiary must provide the health benefit program with the disability determination within 60 days after the latest of (1) the Social Security Administration's determination of disability, (2) the date on which a qualifying event occurs, (3) the date coverage is lost because of the qualifying event, or (4) the date on which the qualified beneficiary is informed of the responsibility to provide the notice. The notice of Social Security disability must also be furnished to the health benefit program before the end of the original 18-month COBRA coverage period.

During COBRA coverage, if the Social Security Administration determines that the qualified beneficiary is no longer disabled, the health benefit program must be informed within 30 days. The notice can be made by providing to the health benefit program a copy of the notice from the Social Security Administration, or by other written means. The notice must properly identify the qualified beneficiary who is no longer disabled and the date the notice of redetermination was received. The 11-month COBRA extension will end at the end of the month in which the redetermination notice from the Social Security Administration is received by the qualified beneficiary.

COBRA second qualifying event extension for spouses and dependents

An 18 or 29-month COBRA coverage period may be extended to 36 months if your spouse (as defined under federal law) or dependents experience additional qualifying events (called

second qualifying events) while they are covered by COBRA.

These events can extend your dependents' 18-month (or 29 month) continuation period to 36 months, but in no event will they have more than 36 months of COBRA measured from the first day of the month following the first qualifying event that originally allowed them to elect coverage.

This extension may be available to the spouse and any dependent children receiving continuation coverage if:

- you die;
- you get divorced or legally separated; or
- if your dependent child stops being eligible under the Plan as a dependent child

but only if the additional event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

However, if termination of employment or reduction of hours follows the employee's Medicare enrollment, the COBRA coverage period for your spouse and dependent children is 36 months from the Medicare enrollment date or 18 months from the subsequent termination or reduction of hours, whichever is longer.

The law requires a qualified beneficiary to notify the health benefit program if any of these additional qualifying events occur. This notice must be provided within 60 days from the latest of (1) the date of the second qualifying event, or (2) the date coverage would have been lost because of the event or (3) the date on which the qualified beneficiary is informed of the responsibility to provide the notice.

Notice of the additional qualifying event must be provided to the health benefit program as directed by your health benefit program. See the materials provided to you by your health benefit program or contact the health benefit program at the address listed in Appendix E.

The notice must include information about the qualified beneficiary requesting additional COBRA coverage and the qualifying event that gave rise to the individual's right to additional COBRA coverage. In addition, the qualified beneficiary may be required to provide the health benefit program with documentation supporting the occurrence of the qualifying event.

If a qualified beneficiary (or his or her representative) fails to provide the appropriate notice and supporting documentation, if required, to the health benefit program during the 60-day notice period, the qualified beneficiary won't be entitled to extended COBRA coverage.

Early Termination of COBRA Coverage

COBRA coverage will terminate before the expiration of the 18-, 29- or 36-month period for the following reasons:

- Your payment for COBRA coverage isn't paid on time (within the applicable grace period), or
- LLNS no longer provides group health coverage to any of its employees.

You will be sent a termination notice to notify you of early termination of COBRA coverage due to the above events.

COBRA coverage will also terminate early if:

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

You are required to inform the health benefit program if you experience the above events. For more information refer to the materials provided by your health benefit program. Or contact your health benefit program at the number listed in Appendix C.

COBRA and FMLA/CFRA leave

Taking an approved leave under the Family and Medical Leave Act of 1993, as amended (an "FMLA leave") and/or the California Family Rights Act (CFRA) isn't considered a qualifying event that would make you eligible for COBRA coverage. However, a COBRA qualifying event occurs if:

- you, your spouse, or your dependent is covered by the program on the day before the leave begins (or you or your dependent becomes covered during the FMLA/CFRA leave); and
- you don't return to employment at the end of the FMLA/CFRA leave and you are not approved to continue leave under LLNS's leave policies or you terminate employment during your leave.

COBRA coverage begins on the earlier of the following:

- when you inform the COBRA Administrator that you are definitely not returning to work; or
- the end of the leave, if you don't return to work and you are not approved to continue leave under LLNS's leave policies.

For additional information on FMLA, such as how to request a leave and other rights and obligations, as well as their impact on Plan benefits, please contact the LLNL Benefits Office or the LLNS Human Resources Personnel Policies Manual, Time Away from Work. You may also contact the Benefits Office at 1-925-422-9955 and ask to speak with a Leave Management Specialist.

COBRA and military leave (USERRA)

If you take a military leave of absence that qualifies as a leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), you may continue medical coverage for up to 24 months as long as you give advance notice (with certain exceptions) of the leave to the LLNL Benefits Office. If the entire length of the leave is 30 days or less, you will not be required to pay any more than the portion you paid before the leave. If the entire length of the leave is 31 calendar days or longer, you may be required to pay up to 102% of the entire cost of the coverage. You can continue medical coverage for the lesser of 24 months, beginning on the date the absence begins, or the length of the leave.

If you take a military leave, but your health benefit program coverage is terminated, for instance, because you do not elect the extended coverage, upon reinstatement you will be treated as if you had not taken a military leave when determining whether an exclusion or waiting period applies upon your reinstatement into the applicable program.

Generally, no exclusions or waiting periods may be imposed upon reinstatement, except exclusions or waiting periods that would normally apply if you had not lost coverage due to your military leave. In addition, certain exceptions are made for an illness or injury that was incurred in or aggravated during the period of military leave.

Under circumstances in which COBRA continuation coverage rights also apply (see "Federal COBRA Continuation Coverage" above for information on COBRA), an election for continuation coverage will be an election to take concurrent COBRA/USERRA health benefit program coverage. In addition, the payment deadlines, requirements and other procedures that apply to COBRA continuation coverage also apply to USERRA health benefit program coverage.

For additional information on military leaves, such as how to request a leave and other rights and obligations, as well as their impact on Plan benefits, please contact the LLNL Benefits Office or the LLNS Human Resources Personnel Policies and Procedures manual, Time Away from Work. You may also contact the Benefits Office at 1-925-422-9955 and ask to speak with a Leave Management Specialist.

COBRA and other leaves of absence

For questions regarding COBRA and disability, workers' compensation, and other leaves, contact the LLNL Benefits Office.

COBRA and Retiree Medical Coverage

If you lose health benefit program coverage under the Plan as an active employee, and are eligible for retiree medical coverage, you can choose

COBRA instead of retiree medical coverage. If you choose COBRA, you will lose your right to elect retiree medical coverage when COBRA ends.

Health Benefit Program Changes During COBRA

While you or your dependents have COBRA coverage, there may be changes to medical, vision, dental, or HCRA benefits, such as new deductibles, covered expenses, or changes to your premiums. All changes will also apply to your COBRA coverage.

Conversion privileges

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

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

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

For additional information on your conversion rights, you should check with your medical benefit provider, or refer to the appropriate benefit program material listed in Appendix B.

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

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

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

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

10. Coordination of Health Care Benefits

When You Have Other Coverage

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

The coordination of benefits rules applicable to you will be those of the benefit program in which you are enrolled and will be furnished automatically to you without charge as a part of the applicable benefit program material. See Appendix B.

If you do not receive the coordination of benefits procedures as a part of the Benefit Program material for health benefits, please contact the LLNL Benefits Office.

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

Here's how it works in general:

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

Which Plan Pays First?

If you or your covered dependents are also covered under another health program, the first of the following rules which applies determines which program is primary:

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

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

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

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

4. For a dependent child whose parents are divorced or separated or are not living together, whether or not they were ever married, and the children are covered under both parents' programs, the birthday rule does not apply. Instead, LLNS uses the following rules to determine which program pays benefits first:

   - first, the program of the parent to whom the court specifically assigned financial responsibility for health care expenses (for

instance, through a Qualified Medical Child Support Order),

- then, the program of the parent who has custody,
- then, the program of the spouse married to the parent who has custody,
- then, the program of the parent who does not have custody, and
- finally, the program of the spouse married to the parent who does not have custody.

5. A program in which a person is enrolled as an active employee (or as that employee's dependent) rather than as a laid-off or retired employee is primary.
6. In most cases, a program in which a person is enrolled as an active employee or subscriber rather than as a COBRA participant is primary.
7. The program covering the person for the longest period of time is considered primary.
8. If none of the above rules determines which program is primary, the allowable expenses shall be shared equally between the programs.

Coordination of Benefits with Medicare

If you continue to work for LLNS after age 65 and are eligible for Medicare, you may continue your medical coverage under a LLNS program and coordinate the program with Medicare. In general, the LLNS program would be primary and pay benefits first for:

- Eligible employees age 65 and over with current employment status and spouses age 65 and over who participate in the LLNS program on the basis of the employee's current employment status. Please note that when Medicare coverage is due to age, Medicare is always the primary payer and this Plan is the secondary payer for a person covered under this Plan as a registered domestic partner or other non-spouse family member.
- Social Security disabled individuals who are covered by the LLNS program on the basis of current employment status (their own or a family member's current employment status) and who are entitled to Medicare benefits (e.g., disabled spouses or dependents of an active employee, or Social Security disabled participants who have returned to work).
- For certain individuals who become eligible for Medicare on the basis of having end-stage renal disease (ESRD), regardless of the reason for the employer coverage, or whether they are eligible for Medicare on the basis of age or disability, for the first 30 months of Medicare entitlement due to ESRD.

You may choose to elect Medicare as primary coverage. If Medicare is elected as primary coverage, the LLNS program is not available.

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

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

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

11. General Plan Provisions

Administration of Plan

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

Plan Amendment and Termination

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

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

If the Plan or a Benefit Program is terminated, coverage upon termination, including any applicable claims run-out period, will be governed by the terms of each Benefit Program, as described in the Benefit Program materials. If the Plan or a Benefit Program is terminated, the rights of participants will be limited to claims incurred before the Plan's termination. In connection with the termination, the Plan Administrator may establish a deadline by which all claims must be submitted for consideration. Benefits will be paid only for covered claims incurred prior to the termination date and submitted in accordance with the rules established by the Plan Administrator. Nothing in this document, the Plan document, or the Benefit Program materials will be construed to provide vested, non-forfeitable, non-terminable, or non-changeable benefits or rights thereto.

Insured Benefits

Certain benefits under this Plan are fully insured. The insurance companies that provide insured benefits under the Plan have been delegated the full discretionary authority to administer the benefits they provide by the Plan. See Appendix D for information on which health and welfare Benefit Programs are insured.

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

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

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

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

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

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

Contributions and Premiums

LLNS' Contributions

LLNS may fund benefits provided under the Plan in whole or in part. Contributions made by LLNS will be made at the times and in the manner determined by LLNS. No assets will be set aside for the purpose of providing benefits under the Plan. LLNS will pay benefits (including any insurance premiums necessary for the purchase of benefits) required under the Plan out of the general assets of LLNS. In no event shall LLNS have any obligation to fund self-funded benefits provided under the Plan in advance of the date that such benefits are payable or pre-pay the premiums or other fees required in order to provide insured benefits under the Plan. LLNS' contribution, if any, may be paid directly to the insurance company or other provider under the Plan. Such payment shall constitute a complete discharge of the liability of the Benefit Program, LLNS and the Plan.

Self-Funded Benefits

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

No Right to Assets

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

Acts of Third Parties

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

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

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

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

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

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

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

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

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

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

As a Plan participant, you are required to:

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

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

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

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

No Estoppel of Plan

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

Thus, if a benefit is paid to a person under the Plan or Benefit Program and it is thereafter determined by the Plan Administrator that such benefit should not have been paid (whether or not attributable to an error by such person, the Plan Administrator or any other person), then the Plan Administrator may take such action as it deems necessary or appropriate to remedy such situation, including without limitation, by deducting the amount of any such overpayment from any succeeding payments to or on behalf of such person under the Plan or Benefit Program or from any amounts due or owing to such person by LLNS or under any other plan, program or arrangement benefiting the employees or former employees of LLNS, or otherwise recovering such overpayment from whoever has benefited from it.

Responsibility for Benefit Programs

Please note that:

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

No Guarantee of Employment

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

Assignment of Benefits

Except as otherwise may be required under a qualified medical child support order (QMCSO) which assigns benefits to a child who has been designated as an alternate recipient in accordance with the Plan's QMCSO procedures; by applicable law; or as otherwise specifically provided in the Plan or Benefit Program material for a fully insured Benefit Program; neither you nor your dependents nor your beneficiaries may assign, sell, transfer, pledge, charge, encumber or allow the attachment or alienation of any amount payable to you, your spouse, dependents, or any beneficiaries at any time under the Plan. Any attempt to so assign, sell, transfer, pledge, charge, encumber or allow the attachment or alienation of any such amount, whether presently or thereafter payable will be void.

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

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

LLNS Use of Funds

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

Plan's Use of Funds

All employee contributions to the Plan, as well as any policy dividends and/or refunds not belonging to LLNS, shall be available without limit to fund the benefits provided by any Benefit Program included in the Plan or any Benefit Program added to the Plan. To the maximum extent permitted by applicable law, the Plan Administrator, at its sole and unfettered

discretion, may use funds accumulated under this Plan for any Benefit Program (whether funds accumulated from insurance contract reserves, insurance company refunds or dividends, participant contributions, or administrative fees) to pay Plan benefits and administrative expenses. Such use of funds may occur without there being any effect on the participant contributions otherwise applicable.

Workers' Compensation

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

Withholding of Taxes

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

12. Your Rights and Privileges under ERISA

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

ERISA provides that all Plan participants have the right to:

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

You can continue health care coverage (medical, vision, dental, employee assistance program, and Health Care Reimbursement Account) for yourself, spouse, and/or your dependents if there is a loss of coverage under the Benefit Program as a result of a qualifying event. You and your dependents may have to pay for such coverage. For more details, review Section 9. Continuation of Health Care Coverage in this SPD, the relevant Benefit Program materials, and the COBRA notice that was mailed to your home. If you need another copy of any of these documents, please contact the LLNL Benefits Office.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

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

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

- Plan fiduciaries misuse the Plan's money, or

- You are discriminated against for asserting your rights.

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

You must file your claim in federal court before the expiration of the Plan's limitations period, as described in the "Claims and Appeals Procedures" section above, or your claim will be dismissed. Any action related to or arising out of or in connection with the Plan may only be brought or filed in the United States District Court, Northern District of California or, if the District Court declines or lacks jurisdiction, in the Superior Court of California for Alameda County.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210 or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-800-444-EBSA (3272) or on the internet at www.dol.gov/agencies/ebsa.

Additional Information

Additional pertinent information is attached as follows:

Appendix A: Premium Contribution Arrangements

Appendix B: Benefit Program Materials

Appendix C: Claim and Appeals Administration Information

Appendix D: Funding and Contract Administration Information

Appendix E: COBRA Administration Contact Information

Appendix F: Plan Administration Information

Appendix A: Premium Contribution Arrangements

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

Benefit	Full Benefits	Mid-level Benefits	
Medical programs	Paid by LLNS and Employee	Paid by LLNS and Employee	
Dental	Paid by LLNS and Employee	N/A	
Basic Vision	Paid by LLNS and Employee	N/A	
Employee Assistance Program (EAP)	Paid by LLNS	Paid by LLNS	
Basic Life	Paid by LLNS	N/A	
Supplemental Life	Paid by Employee	Paid by Employee	
Dependent Life (Basic and Expanded)	Paid by Employee	Paid by Employee	
Accidental Death and Dismemberment (AD&D)	Paid by Employee	Paid by Employee	
Supplemental Disability	Paid by Employee	N/A	
LLNS Defined Benefit Eligible Disability Program	Paid by LLNS (certain participants in the LLNS Defined Benefit Pension Plan only)		
Business Travel Accident	Paid by LLNS	Paid by LLNS	
Legal	Paid by Employee	Paid by Employee	
Health Care Reimbursement Account (HCRA)	Paid by Employee	Paid by Employee	
Dependent Care Reimbursement Account (DCRA)	Paid by Employee	Paid by Employee	
Long-Term Care Benefit	Paid by Employee	Paid by Employee	
Severance	Paid by LLNS (certain Employees only)		
LLNS Defined Benefit Eligible Survivor Income Program	Paid by LLNS (certain participants in the LLNS Defined Benefit Pension Plan only)		

Appendix B: Benefit Program Materials

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

Benefit Program Material	
Medical	
Anthem Blue Cross of California	
Anthem Blue Cross PLUS	Employees and Retirees In California without Medicare Evidence of Coverage and Disclosure Form
	CVS/Caremark (Prescription Drug Benefit)
Anthem Blue Cross PPO	Employees and Retirees In California without Medicare Evidence of Coverage and Disclosure Form
	CVS/Caremark (Prescription Drug Benefit)
Core Value with HSA	Employees and Retirees In California without Medicare
	CVS/Caremark (Prescription Drug Benefit)
Anthem Blue Cross EPO	Employees and Retirees In California without Medicare Evidence of Coverage and Disclosure Form
	CVS/Caremark (Prescription Drug Benefit)
Anthem Blue Cross HDHP with HSA	Employees In California without Medicare Evidence of Coverage and Disclosure Form
	CVS/Caremark (Prescription Drug Benefit)
Kaiser	
Kaiser California HMO (Non Medicare	Kaiser Permanente Traditional HMO Plan Evidence of Coverage for Lawrence Livermore National Security, LLC, Northern California Kaiser Permanente Traditional HMO Plan Evidence of Coverage for Lawrence Livermore National Security, LLC, Southern California
Kaiser California HDHP (Non Medicare)	Kaiser Permanente Traditional HMO Plan Evidence of Coverage for Lawrence Livermore National Security, LLC, Northern California Kaiser Permanente Traditional HMO Plan Evidence of Coverage for Lawrence Livermore National Security, LLC, Southern California
Kaiser Hawaii	Kaiser Foundation Health Plan, Inc., A Nonprofit Health Plan – Hawaii Region, Group Agreement
Dental	
Delta Dental of California PPO	LLNS Employees, Retirees and their Dependents Delta Dental PPO Evidence of Coverage and Disclosure Statement
DeltaCare® USA	DeltaCare® USA Dental Health Care Program for Eligible Employees, Eligible Retirees and Dependents Combined Evidence of Coverage and Disclosure Statement
Vision	
Vision Service Plan	Group Vision Care Benefit Program VSP Benefit Program Summary Evidence of Coverage and Disclosure Form
Employee Assistance Program (EAP)	
EAP	Concern: Employee Assistance Program “Combined Evidence of Coverage and Disclosure Form” (EOC) Benefit Program Summary

	Benefit Program Material
Life Insurance	
Basic, Core and Supplemental Life	Lawrence Livermore National Security, LLC Employee Term Life Coverage Basic, Core and Supplemental Plans and Dependent Term Life Coverage Basic and Expanded Plans Prudential
Basic and Expanded Dependent Life	Lawrence Livermore National Security, LLC Employee Term Life Coverage Basic, Core and Supplemental Plans and Dependent Term Life Coverage Basic and Expanded Plans Prudential
Accidental Death & Dismemberment (AD&D)	
AD&D	Personal Accident Insurance Plan Benefit Program Summary for Eligible Employees of LLNS and their Families
Supplemental Disability	
Supplemental Disability	Supplemental Disability Insurance Plan (The Hartford)
Defined Benefit Eligible Disability Program	
Defined Benefit Eligible Disability Program	LLNS Defined Benefit Eligible Disability Program Benefit Program Summary
Business Travel Accident (BTA)	
BTA	LLNS Business Travel Accident Program Benefit Program Summary (AIG)
Legal Plan	
Legal Plan	Group Legal Services Plan Policy of Insurance
Health Care Reimbursement Account/Dependent Care Reimbursement Account	
HCRA DCRA	LLNS Health Care Reimbursement Account (HCRA) and Dependent Care Reimbursement Account (DCRA) Benefit Program Summary
Severance Plan	
Severance Plan	LLNS Severance Plan Benefit Program
Defined Benefit Eligible Survivor Income Program	
Defined Benefit Eligible Survivor Income Program	LLNS Defined Benefit Eligible Survivor Income Program Benefit Program Summary

Please contact the **LLNL Benefits Office** if you do not receive the Benefit Program material for the program in which you are enrolled.

Appendix C: Claim and Appeals Administration Information

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

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

Benefit Program	Claims Administrator for ERISA Claims and Appeals	
Medical		
Anthem Blue Cross of California		
• **Anthem Blue Cross PLUS** • **Anthem Blue Cross EPO** • **Anthem Blue Cross PPO** • **Anthem Blue Cross HDHP with HSA** • **Anthem Blue Cross Core***	Anthem Blue Cross of California P.O. Box 60007 Los Angeles, CA 90060-0007 866-641-1689 www.anthem.com	
Kaiser		
• Kaiser Traditional Plan • Kaiser HDHP with HSA	**Northern California** Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 12923 Oakland, CA 94604-2923 www.kaiserpermanente.org	**Southern California** Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 7004 Downey, CA 90242-7004 www.kaiserpermanente.org
Kaiser Hawaii	**Claims Submission** **Kaiser Foundation Health Plan, Inc.** **Attn: Claims Administration** **PO Box 378021** **Denver, CO 80237** www.kaiserpermanente.org	**Appeals:** **Kaiser Foundation Health Plan, Inc.** **Attn: Regional Appeals Office** **711 Kapiolani Blvd.** **Honolulu HI 96813** www.kaiserpermanente.org
Dental		
Delta Dental PPO	Delta Dental of California P.O. Box 99730 Sacramento, CA 95899-7330 800-777-5854 www.deltadentalca.org	Appeals: Customer Service Department P.O. Box 99730 Sacramento, CA 95899-7330 800-777-5854 www.deltadentalca.org
DeltaCare USA	Claims Department 1800 Studebaker Road, Ste 530 Cerritos, CA 90730 800-422-4234 CS-Cerritos@delta.org	
Vision		
Vision Service Plan (VSP)	VSP P.O. Box 997105 Sacramento, CA 95899-7105 800-877-7195 www.vsp.com	Appeals: Member Appeals 3333 Quality Drive Rancho Cordova, CA 95670 800-877-7195 www.vsp.com

Benefit Program	Claims Administrator for ERISA Claims and Appeals
Employee Assistance Program (EAP)	
Concern	Concern Employee Assistance Program Concern Health 2490 Hospital Drive Suite 310 Mountain View, CA 94040 800-344-4222
Basic and Core, Dependent, and Supplemental Life	
MetLife	Metropolitan Life Insurance Company 200 Park Avenue New York, NY 10166 800-638-6420
Accidental Death & Dismemberment (AD&D)	
AIG	AIG Domestic Claims Accident & Health Claims Department Post Office Box 25987 Shawnee Mission, KS 66225-5987 800-551-0824

*Does not include prescription drug/mental/behavioral health/substance abuse.

Short-Term Disability (STD) (out of California) & Supplemental Disability	
The Hartford Group	The Hartford Group Benefits Division Post Office Box 2999 Hartford, CA 06104-2999 888-563-1124 www.TheHartfordatwork.com
LLNS Defined Benefit Eligible Disability Program	
The Hartford Group	The Hartford Group Benefits Division Post Office Box 2999 Hartford, CT 06104-2999 800-523-2233 www.TheHartford.com
Business Travel Accident (BTA)	
Travelers Bond & Specialty Insurance Claim	Travelers Bond & Specialty Insurance Claim 385 Washington Street Mail Code 9275-NB03F St. Paul, MN 55102 Email: BSIclaims@travelers.com FAX: 888.460.6622
Legal	
MetLife Legal	MetLife Legal Plans, Inc. 1111 Superior Avenue Cleveland, Ohio 44114
Dependent Care Reimbursement Account (DCRA) **(not an ERISA benefit; included for convenience only)**	
HealthEquity	HealthEquity Spending Accounts 15 West Scenic Pointe Drive, Suite 100 Draper, UT 84020, United States Ph: 866.346.5800

Benefit Program	Claims Administrator for ERISA Claims and Appeals
Health Care Reimbursement Account (HCRA)	
HealthEquity	HealthEquity Spending Accounts 15 West Scenic Pointe Drive, Suite 100 Draper, UT 84020, United States Ph: 866.346.5800
Severance	
LLNS Plan Administrator	LLNL Benefits Office See contact information on page 2
LLNS Defined Benefit Eligible Survivor Income Program	
LLNS Plan Administrator	LLNL Benefits Office See contact information on page 2
COBRA Administrator	
LLNS Plan Administrator	LLNL Benefits Office See contact information on page 2

Appendix D: Funding and Contract Administration/Insurance Company Information

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

BENEFIT PROGRAM	CONTACT INFORMATION	TYPE OF FUNDING
Medical		
Anthem Blue Cross of California		
Anthem Blue Cross PLUS **Anthem Blue Cross EPO** **Anthem Blue Cross PPO** **Anthem Blue Cross HDHP with HSA** **Anthem Blue Cross Core with HSA**	Anthem Blue Cross of California 21215 Burbank Boulevard Woodland Hills, CA 91367 877-359-9654	self-insured
▪ CVS/Caremark (Prescription Drug Benefit)	CVS/Caremark P.O. Box 52196 Phoenix, AZ 85072-2196 1-866-623-1438 www.caremark.com	self-insured
Kaiser		
▪ Kaiser California (Non Medicare)	Kaiser Foundation Health Plan, Inc. Special Services Unit P.O. Box 23280 Oakland, CA 94623 800-464-4000 800-777-1370 (hearing impaired) http://kp.org	insured
• Kaiser Hawaii	Kaiser Permanente Hawaii Regional Office 711 Kapiolani Boulevard Honolulu, HI 96813 1-833-833-3333	insured
Dental		
Delta Dental PPO	Delta Dental of California P.O. Box 997330 Sacramento, CA 95899-7330 800-777-5854 http://www.deltadentalins.com/llns	self-insured
DeltaCare USA	DeltaCare USA 1800 Studebaker Road Cerritos, CA 90730 800-422-4234 http://www.deltadentalca.org/deltacareusa	insured
Legal		
MetLife Legal	MetLife Legal Plans, Inc. 1111 Superior Avenue Cleveland, Ohio 44114	insured

BENEFIT PROGRAM	CONTACT INFORMATION	TYPE OF FUNDING
Accidental Death & Dismemberment (AD&D)		
AIG .	AIG Domestic Claims Accident & Health Claims Department Post Office Box 25987 Shawnee Mission, KS 66225-5987 800-551-0824	insured
Vision		
Vision Service Plan	Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670 800-877-7195 www.vsp.com	insured
Employee Assistance Program (EAP)		
Concern Employee Assistance Program	Concern Health 2490 Hospital Drive Suite 310 Mountain View, CA 94040 800-344-4222	insured
Basic and Core, Dependent, and Supplemental Life		
MetLife	Metropolitan Life Insurance Company 200 Park Avenue New York, NY 10166 800-638-6420	insured
Short-Term Disability (STD) Supplemental Disability		
The Hartford	The Hartford Group Benefits Division Post Office Box 2999 Hartford, CT 06104-2999 800-523-2233 www.TheHartford.com	insured
LLNS Defined Benefit Eligible Disability Program		
The Hartford	The Hartford Group Benefits Division Post Office Box 2999 Hartford, CT 06104-2999 800-523-2233 www.TheHartford.com	self-funded
Business Travel Accident (BTA)		
Travelers Bond & Specialty Insurance Claim	Travelers Bond & Specialty Insurance Claim 385 Washington Street Mail Code 9275-NB03F St. Paul, MN 55102 Email: BSIclaims@travelers.com FAX: 888.460.6622	insured

BENEFIT PROGRAM	CONTACT INFORMATION	TYPE OF FUNDING
Dependent Care Reimbursement Account (DCRA) (not an ERISA benefit; included for convenience only)		
HealthEquity	HealthEquity Spending Accounts 15 West Scenic Pointe Drive, Suite 100 Draper, UT 84020, United States Ph: 866.346.5800	self-funded
Health Care Reimbursement Account (HCRA)		
Health Equity	HealthEquity Spending Accounts 15 West Scenic Pointe Drive, Suite 100 Draper, UT 84020, United States Ph: 866.346.5800	self-funded
Severance		
LLNS	LLNS Self-administered by LLNS LLNL Benefits Office See contact information on page 2	self-funded
LLNS Defined Benefit Eligible Survivor Income Benefit		
LLNS	LLNS Self-administered by LLNS LLNL Benefits Office See contact information on page 2	self-funded

Appendix E: COBRA Administration Contact Information

Benefit Program	COBRA Contact
Medical	
Anthem Blue Cross PLUS Anthem Blue Cross EPO Anthem Blue Cross PPO Anthem Blue Cross HDHP with HSA Anthem Blue Cross Core with HSA	COBRA and Direct Bill Services HealthEquity 15 W Scenic Pointe Dr #100 Draper, Utah 84020 877-775-9393
Kaiser California	COBRA and Direct Bill Services HealthEquity 15 W Scenic Pointe Dr #100 Draper, Utah 84020 877-775-9393
Dental	
Delta Dental PPO	COBRA and Direct Bill Services HealthEquity 15 W Scenic Pointe Dr #100 Draper, Utah 84020 877-775-9393
DeltaCare	COBRA and Direct Bill Services HealthEquity 15 W Scenic Pointe Dr #100 Draper, Utah 84020 877-775-9393
Vision	
Vision Service Plan (VSP)	COBRA and Direct Bill Services HealthEquity 15 W Scenic Pointe Dr #100 Draper, Utah 84020 877-775-9393
Flexible Spending Account	
Health Care Reimbursement Account (HCRA)	COBRA and Direct Bill Services HealthEquity 15 W Scenic Pointe Dr #100 Draper, Utah 84020 877-775-9393
Employee Assistance	
Concern	COBRA and Direct Bill Services HealthEquity 15 W Scenic Pointe Dr #100 Draper, Utah 84020 877-775-9393

Appendix F: Plan Administration Information

Official Plan Name	LLNS Health & Welfare Benefit Plan for Employees (See Appendix B for a listing of Benefit Programs applicable to this SPD).	
Employer/Plan Sponsor	**Lawrence Livermore National Security, LLC**	Mailing Address P.O. Box 808, L-642 Livermore, CA 94551 Street Address 7000 East Ave., L-642 Livermore, CA 94550
Employer I.D. Number (EIN)	20-5624386	
Plan Number	501	
Type of Plan	The Benefit Programs are welfare benefit plans which may include medical, dental, vision, employee assistance, life, accidental death and dismemberment, disability, business travel accident, legal, health care reimbursement account, severance, and survivor income benefits.	
Type of Administration/ Insurance Issuers	The Benefit Programs are provided under both self-funded and insured arrangements. The insured programs are provided under group contracts between LLNS and the carriers. The carriers – not LLNS – have full discretionary authority to determine eligibility for benefits, the amount of any benefits payable, and for prescribing the claims procedures for the insured programs.	
Plan Funding Medium	The insured arrangements are paid by insurance policies. The benefits and other costs (such as administrative costs) for the self-funded programs and insurance premiums for the insured benefits are paid from the general assets of LLNS and participant contributions.	
Plan Administrator	**Lawrence Livermore National Security, LLC** **Benefits and Investment Committee**	Mailing address: P.O. Box 808, L-642 Livermore, CA 94551 Street Address: 7000 East Ave., L-2Livermore, CA 94550 925-422-9955
Claims Administrator	See Appendix C.	
Agent for Service of Legal Process	**Lawrence Livermore National Security, LLC** Service of legal process may also be made upon the Plan Administrator (see above).	Lawrence Livermore National Security, LLC 2300 First Street Ste. 204 Livermore, CA 94550
Plan Year	January 1 – December 31	

Contribution Sources	LLNS and participant contributions The cost of a Benefit Program is determined as follows: (1) for the fully insured Benefit Programs, the cost is based on the premium charged by the insurer; and (2) for the self-funded Benefit Programs, the cost is based on the claims paid under the Benefit Program, plus administrative expenses. LLNS, in its sole discretion, will determine what portion of the cost LLNS will cover, if any, for each Benefit Program.