Lawrence Livermore National Laboratory

Benefits

2027

OPEN ENROLLMENT

LAWRENCE LIVERMORE NATIONAL SECURITY LLC

RETIREE GUIDE

October 26 – November 13 (Empyrean)
October 15 - December 7 (Via Benefits)

Changes made during this enrollment period become effective January 1, 2027.

NOTICE

If you are enrolled in Medicare or will become eligible to enroll in Medicare during 2027, a federal law gives you more choices about your prescription drug coverage. Please see page 11 for more details.

Attention: Medicare-Eligible Retiree

Tips to help you through Open Enrollment
Review materials received to understand your options:

- LLNS - 2027 Retiree Open Enrollment guide and materials
- Empyrean - Personal Enrollment Worksheet
- Via Benefits - Fall Newsletter and HRA Reminder Letter
- Medicare - Medicare & You 2027

You may need to change your benefits if:

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

Contact Empyrean at (844) 750-5567 or Via Benefits at (866) 682-4841 to make changes. Elect your Medicare Supplement through Via Benefits or Kaiser Permanente Senior Advantage in California through Empyrean to be eligible for the HRA. Do not elect a plan through an independent broker or directly through the plan or you may lose your HRA funding.

When calling Via Benefits
Enter your information when prompted. This will bring up your information to the representative and reduce repeating your information.

Schedule an appointment–appointments are given on a first come, first served basis. New appointments may be added as advisors become available. Appointment availability is spread throughout the enrollment period.

Expect to be on hold when calling during your scheduled appointment time. Your advisor may be ending a call with the previous retiree. Appointment times are estimates.

About Empyrean
If you made arrangements to have HRA payments made directly to Empyrean, they will automatically continue in 2027. If you would like to opt out of HRA payments being made directly to Empyrean, please contact the Kaiser HRA payment Center at (877) 761-3399. If you do not want to make any changes to your current plan elections, they will continue into 2027 unless you have been notified otherwise.

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

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Lawrence Livermore National Laboratory

2027

Retiree Guide

Lawrence Livermore National Laboratory

The information and descriptions in this Enrollment Guide are intended to be a summary of available benefits so you can consider alternatives suitable to your personal circumstances and requirements. Nothing in this document should be construed as creating any entitlement or contractual rights.

For plans governed by ERISA, this 2027 Open Enrollment Guide is a Summary of Material Modifications to the LLNS Health and Welfare Benefit Plan for Retirees Summary Plan Description (October 2017) (the "SPD"). The SPD, along with the applicable summary plan descriptions, evidence of coverage, and disclosure forms or successor documents to such documents, as well as any Summaries of Material Modification, together constitute the official Plan document and Summary Plan Description for the Plan (the "Plan Documents").

For eligibility rules for TCP1, TCP2 and the retiree health insurance, please reference the Summary Plan Descriptions found on the Benefits Office website: https://benefits.llnl.gov

LLNS reserves the right to amend or discontinue any benefit plan at any time.

If there is a conflict between this Enrollment Guide and the terms of the Plan documents, the Plan documents will govern.

This guide is structured in five sections

Information that applies to:

- All retirees and eligible dependents
- Those not eligible for Medicare
- Medicare eligible—currently in Kaiser
- Medicare eligible—not currently in Kaiser
- Plan Comparison Charts (medical, dental and vision)

This year, Empyrean will conduct a virtual Open Enrollment presentation that will be held on Wednesday, October 21, 2026, from 9:00 a.m. to 10:00 a.m. Pacific Time.

For details see back page of this guide.

In addition to this guide, you will also receive information from Empyrean on your current coverages and options available for 2027. If you are eligible for Medicare, you will also receive information from Via Benefits.

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

If you do not want to make any changes to your current medical, dental, vision or legal plan elections, no action is required. If you want to enroll in the Vision Choice Plan, see page 29 for more details.

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

All Retirees & Eligible Dependents

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

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

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

Actions Permitted Outside of Open Enrollment (Qualifying Life Event)
You can change your benefit elections outside of Open Enrollment if certain events occur within 31 days of the Qualifying Life Event. Generally, the event must affect eligibility, and the election change must be due to and correspond with the event. Medical, dental, legal, and vision plan elections may be changed during the calendar year only if you have a Qualifying Life Event. Such events include:

- A change in your legal marital status or registered domestic partnership, including marriage, divorce, death of your spouse or registered domestic partner, legal separation, or annulment.
- A change in the number of your dependents including through birth, adoption, placement for adoption, or death.
- A change in employment status by you, your spouse, registered domestic partner, or dependent that results in gaining or losing eligibility for coverage.
- Your dependent's ability or inability to satisfy dependent eligibility requirements.
- A change in residence by you, your spouse, or registered domestic partner, or dependent that causes you to lose access to providers in your plan's network.
- For more information, see the LLNS Health and Welfare Benefit Plan for Retirees Summary Plan Description (October 2017) located at https://www.llnl.gov/sites/www/files/2021-06/LLNS-Retirees-SPD.pdf

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

Dependent Eligibility
If an enrolled family member loses eligibility during the year, you are responsible for de-enrolling that family member. Do not wait until Open Enrollment. A child who turns 26 is automatically de-enrolled by LLNS (legal wards are de-enrolled at age 18). You are responsible for costs related to the enrollment of ineligible family members and you could be subject to costs associated with the misuse of the plan if you continue coverage for family members who no longer meet LLNS eligibility rules. For more information see the LLNS Health and Welfare Benefit Plan for Retirees Summary Plan Description (October 2017). Questions about eligibility should be directed to Empyrean's Customer Care Center at (844) 750-5567.

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

Dental Benefit Choices

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

There are no dental plan design changes for 2027. A dental plan comparison chart is on page 28. Plan coverage details for 2027 are available by contacting Empyrean's Customer Care Center (844) 750-5567 or at **www.llnsretireebenefits.com**. Please note there is a difference in the networks between these two plans. The Delta Dental PPO plan allows you to see any licensed dentist. The DeltaCare USA plan limits access to DeltaCare USA network dentists. If you have elected DeltaCare USA, make sure your dentist participates in the network and accepts new patients by calling DeltaCare USA at (800) 422-4234.

Legal Insurance
MetLife Legal Plan is the country's largest provider of group legal benefits. The plan covers members, spouses, and dependents and gives them access to more than 18,000 attorneys who can provide legal consultation and representation on a broad range of covered issues. The cost of the MetLife Base Plan covers services such as divorce without an hour limit, probate, custody and child support matters, Aura identity theft, and personal property matters. There are no changes to rates for 2027.

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

Finally, cover your loved ones with the MetLife Enhanced Plan–Plus Parents. With this plan, you and your dependents will be covered under the Enhanced Plan design. This plan also covers up to eight parents in your legal plan and provides them access to services, including estate planning and eldercare issues. Parent(s) are only covered for a subset of full plan coverage. Legal plan billing is handled by Empyrean. Plan payments can be made to them by direct debit or check. Additional information on covered benefits can be found at https://www.llnl.gov/join-our-team/benefits/health-welfare/legal-insurance.

Legal Insurance (Monthly Rate)

- Base Plan $12.30
- Enhanced $18.30
- Enhanced + Parents $24.30

Vision Plans

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

See the chart on page 29 for a comparison of the benefit coverages for the two options. To locate a VSP provider, log on to www.vsp.com or call (800) 877-7195. To enroll in the Vision Choice plan, contact Empyrean at (844) 750-5567 or log on to www.llnsretireebenefits.com.

Vision - Monthly Rates	Vision Discount	Vision Choice
Retiree Only	$0	$9.37
Retiree & Spouse / Registered Domestic Partner	$0	$18.75
Retiree & Child(ren)	$0	$20.06
Retiree & Family	$0	$32.07

Accidental Death & Dismemberment (AD&D)

There are no plan design or rate changes in 2027. AD&D insurance protects you and your family from the unforeseen financial hardship of an accident that causes death, dismemberment, or loss of sight, speech, or hearing. The plan provides worldwide coverage for you and your enrolled family members. Coverage details are available by contacting AIG at (877) 202-1346.

2027 AD&D Monthly Rates (Per $1K of Coverage)	
Retiree Only	$0.90
Retiree & Spouse	$1.40

An age-based benefit reduction will begin at age 70 on the following schedule	
<70	100%
70 - 75	65%
75 - 80	45%
80 - 85	30%
85+	15%

Medicare "Split Family" Enrollment

When a retiree and/or dependent reaches age 65, he or she becomes eligible to participate in a Medicare plan. If a retiree is Medicare eligible and a spouse/registered domestic partner is not (or vice versa), this is known as a "split family". Each person's corresponding available options will appear on the enrollment worksheet you will receive from Empyrean and on the LLNS Retiree Benefits website so that separate elections can be made. All retirees and dependents in a "split family" situation are able to review and make separate elections based on their individual eligibility. If you or your dependent will become Medicare eligible in 2027, you will receive information on your new enrollment options about 120 days prior to your or your dependent's 65th birthday.

Direct Debit

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

Beneficiaries

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

Contact the following organizations to change your beneficiary designation:

LLNS 401(k) plans	Fidelity	800-835-5095
AD&D	AIG	877-202-1346
Pension Single Sum Death Benefit (TCP1)	LLNS Pension Center	866-655-9587
UCRP Lump Sum Death Benefit	UCRP	800-888-8267
PERS Death Benefit	PERS	888-225-7377

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

Required Notices

Notice of Availability of Notice of Privacy Practices

The LLNS Health and Welfare Benefit Plan for Retirees (the "Plan") provides health benefits to eligible retirees of Lawrence Livermore National Security, LLC (the "Company") and their eligible dependents as described in the Summary Plan Description for the Plan. The Plan creates, receives, uses, maintains, and discloses health information about participating retirees and dependents in the course of providing these health benefits. The Plan is required by law to provide notice to participants of the Plan's duties and privacy practices with respect to covered individuals' protected health information ("PHI"), and has done so by providing to Plan participants a notice of privacy practices, which describes the ways that the Plan uses and discloses PHI. To receive a copy of the Plan's notice of privacy practices, you can go to the Benefits web site http://benefits.llnl.gov (select "Retirees" tab and click on "Privacy Notice").

The Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 requires that if a group health plan provides medical and surgical benefits for mastectomies, it must also provide coverage for re-constructive surgery and prostheses following mastectomies. The law mandates that a participant or beneficiary who is receiving benefits under the plan for a covered mastectomy, and who elects breast reconstruction in connection with the mastectomy, will also receive coverage for:

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

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

Important Notice from LLNS about Your Prescription Drug Coverage and Medicare

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

There are two important things you need to know about your current coverage and Medicare prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- LLNS has determined that the prescription drug coverage offered by the LLNS Health and Welfare Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage. Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th

through December 7th. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a two-month Special Enrollment Period (SEP) to join a Part D plan because you lost creditable coverage. In addition, if you lose or decide to leave employer sponsored coverage, you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

If you do decide to join a Medicare prescription drug plan and drop your LLNS medical coverage (which includes prescription drug coverage), be aware that you and your dependents may not be able to get this coverage back until the calendar year after the following Open Enrollment period. Remember, your current LLNS medical coverage pays for other health expenses, in addition to prescription drugs. Contact Via Benefits for more information about what happens to your coverage if you join a Medicare prescription drug plan. You should also know that if you drop or lose your coverage with LLNS and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 consecutive days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium may go up at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

Contact Via Benefits at (866) 682-4841 for further information. More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare, unless you sign up to receive it electronically. You may also be contacted directly by Medicare drug plans. For more information about Medicare drug coverage:

NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through LLNS changes.

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

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

HIPAA Special Enrollment Rights (Health Insurance Portability and Accountability Act of 1996)
If you are declining enrollment in medical/dental coverage for yourself or your eligible dependents (including your spouse, registered domestic partner, dependent children and registered domestic partner's dependent children) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in medical/dental coverage if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent due to marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself

and your dependents. Your special enrollment request must be made within 31 days after the marriage, birth, adoption, or placement for adoption. Contact Empyrean at (844) 750-5567 for more information.

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

- Anthem Blue Cross Plus
- Anthem Blue Cross PPO
- Anthem Blue Cross EPO
- Anthem Blue Cross Core Value
- Anthem Blue Cross HDHP

Kaiser Permanente
The SBCs for LLNS' plans are posted on the Empyrean LLNS Retiree website www.llnsretireebenefits.com or on the LLNS Benefits website https://benefits.llnl.gov. You also have the right to request a hard copy of the SBC(s) free of charge by calling the Empyrean Customer Care center at (844) 750-5567. Please note that these SBCs do not apply to you if your coverage is through an individual policy administered by Via Benefits

SUMMARY ANNUAL REPORT
For LLNS Health & Welfare Benefit Plan for Retirees
This is a summary of the annual report of the LLNS Health & Welfare Benefit Plan for Retirees (Employer Identification Number 20-5624386, Plan Number 502) for the plan year 01/01/2025 through 12/31/2025. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

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

Insurance Information
The plan has insurance contracts with Kaiser Foundation Health Plan Inc., Delta Dental of California, National Union Fire Ins. Co. of Pittsburgh, PA, Vision Service Plan and Metropolitan General Insurance Company to pay certain medical, dental, vision, accidental death & dismemberment and legal claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2025 were $44,170,056.

Because they are so called "experience-rated" contracts, the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending 12/31/2025, the premiums paid under such "experience-rated" contracts were $340,230 and the total of all benefit claims paid under these experience-rated contracts during the plan year was $309,610.

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

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

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

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

OMB Control Number 1210-0040 (expires 07/31/2029)

Medical

For Those Not Eligible for Medicare

Plan Changes for 2027

- Anthem Blue Cross HDHP deductible will be $1,750 for individual and $3,500 for family.
- Rates for 2027 will be provided by Empyrean in a separate mailing.
- IMPORTANT: Details are contained in the medical plan comparison chart that begins on page 22.
- Be sure to carefully review this information.

Anthem Blue Cross Plus, PPO, and Core Value

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

What You Need to Do During Open Enrollment

Review all information received.

Empyrean will continue to administer non-Medicare eligible enrollees for medical coverage. Empyrean will continue to administer dental, legal and vision coverages for all retirees and their eligible dependents.

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

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

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

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

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

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

Please note that Empyrean Open Enrollment lines open at 7:00 a.m. Pacific time on Monday, October 26, 2026.

The last day to make an election is Friday, November 13, 2026, 5:00 p.m. Pacific time.

Medical Plan Choices
You are encouraged to evaluate your options to ensure that the choice you made for the current year still meets your needs. A more detailed explanation of plan coverages and exclusions are available from Empyrean. The non-Medicare plans available for 2026 include:

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

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

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

Health Savings Account (HSA)
The Anthem Blue Cross Core Value plan and Anthem HDHP are HSA compatible. An HSA is a tax-advantaged account which can be used to save money for eligible medical expenses. If you enroll/are enrolled in the Core Value option or the HDHP you can set up an HSA through most financial institutions. The financial institution will provide you with details about eligible expenses, how much you can contribute, etc.

NOTE: If you are enrolled in any other medical plan, including Medicare (Part A and/or B), you are not eligible for the HSA.

Mandatory Maintenance Prescription Mail Order Program

For Anthem Blue Cross plans, the mandatory mail order program for maintenance medications remains in effect in 2027. CVS/Caremark offers the Maintenance Choice program which allows you to fill a mandatory mail order drug at a local CVS pharmacy for the same cost as mail order.

You can call CVS/Caremark Customer Service at (866) 623-1438 with any questions you may have about their services.

Mental Health and Substance Abuse Benefits
LLNS medical plans include mental health and substance abuse benefits as follows:

Kaiser: Kaiser members continue to access all mental health and substance abuse services through Kaiser physicians or facilities.

Anthem Blue Cross Plans: All mental health and substance abuse services are provided by Anthem Blue Cross. To ensure full coverage of your services, contact Anthem Blue Cross for authorization of your visits.

Refer to the medical plan comparison chart that begins on page 22 for benefit details.

Medical

For Those Medicare Eligible and Currently in Kaiser Permanente Senior Advantage (KPSA)

KPSA in CA will be:
$317.55/Month/Person

What You Need to Do During Open Enrollment

Carefully review all Open Enrollment information you receive to make the best decision for your situation. If you want your coverage to remain with Kaiser, do nothing this Open Enrollment and your coverage will continue with Kaiser.

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

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

You must be enrolled in KPSA (Outside of California) or a medical plan through Via Benefits to receive the HRA for 2027.

Empyrean Open Enrollment lines open at 7:00 a.m. Pacific time on Monday, October 26, 2026. The last day to make an election is Friday, November 13, 2026, 5:00 p.m. Pacific time.

Contact Empyrean
(844) 750-5567
www.llnsretireebenefits.com

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

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

Health Reimbursement Arrangement (HRA)
Each year LLNS contributes a designated amount to your HRA—a special, tax-free, employer-funded account you use to pay for eligible medical expenses and prescription drugs. The employer contribution is prorated to your graduated eligibility based on your years of service determined at the time of your retirement. For 2027, the maximum contribution will remain at $2,450 for each Medicare eligible retiree and Medicare eligible dependent.

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

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

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

If you made arrangements to have HRA payments made directly to Empyrean they will automatically continue in 2027. If you would like to opt out of HRA payments being made directly to Empyrean, please contact the Kaiser HRA payment Center at (877) 761-3399.

To request reimbursement for out of pocket medical or prescription expenses, contact Kaiser HRA Payment Center at (877) 761-3399.

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

Medical

For Those Medicare eligible and not in Kaiser Permanente Senior Advantage (KPSA) in California

What You Need to Do During Open Enrollment
Review all information received

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

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

If you do not make a new plan selection with Via Benefits, you will remain in the same plan in 2027.
You must be enrolled in a medical plan through Via Benefits or Kaiser (Outside of California) to receive HRA contributions for 2027.

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

Please note that while your plan will continue in 2027, benefits and costs may change. Review all information from your individual plan.

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

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

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

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

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

Contact Via Benefits
(866) 682-4841
www.viabenefits.com

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

Via Benefits Open Enrollment phone lines open at 5:00 a.m. Pacific time on October 15, 2026 and will close December 7, 2026. The last day to make an election online is December 7, 2026, 6:00 p.m. Pacific time.

Contact Empyrean
(844) 750-5567
www.llnsretireebenefits.com

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

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

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

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

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

Remember:
Please note that Empyrean Open Enrollment lines open at 7:00 a.m. Pacific time on Monday, October 26, 2026. The last day to make an election is Friday, November 13, 2026, 5:00 p.m. Pacific time. After your election has been made, a confirmation statement will be mailed to your address of record.

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

After you receive confirmation of your enrollment, notify Via Benefits by submitting proof of enrollment (e.g. KPSA card, enrollment letter).

Via Benefits will continue to administer the HRA for retirees enrolled in a KPSA plan outside of California. The address is:

Alicia Merrill
Willis Towers Watson Via Benefits
38 East Scenic Pointe Drive, Suite 200
Draper, UT 84020

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

Health Reimbursement Arrangement (HRA)
Each year LLNS contributes a designated amount to your HRA—a special, tax-free, employer-funded account you use to pay for eligible medical expenses and prescription drugs. You must be enrolled in a Medicare plan through Via Benefits to be eligible for the HRA funds. The employer contribution is prorated to your graduated eligibility based on your years of service determined at the time of your retirement. For 2027, the maximum contribution will remain at $2,450 for each Medicare eligible retiree and Medicare eligible dependent. There is no reimbursement for Part B but your HRA money can be used for this expense. Any unused amount in your HRA will rollover to the next year. Further details about the HRA are available from Via Benefits. Your benefit dollars will be placed in an HRA account that you can use to pay for eligible medical expenses and prescription drugs.

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

For more information contact Via Benefits Administrators at (866) 682-4841.

Lawrence Livermore National Laboratory

Benefits

LAWRENCE LIVERMORE NATIONAL SECURITY LLC

PLAN COMPARISION CHARTS

2027 Medical Plan Options Comparison of Benefit Coverages

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser	Kaiser Senior Advantage
Member Services	1-866-641-1689	1-866-641-1689	1-866-641-1689	1-866-641-1689	1-866-641-1689	1-800-464-4000	1-800-443-0815
Website	www.anthem.com/ca/llns/	www.anthem.com/ca/llns/	www.anthem.com/ca/llns/	www.anthem.com/ca/llns/	www.anthem.com/ca/llns/	https://choose.kp.org/llns	https://choose.kp.org/llns
Annual Deductible (Individual/Family, In Network)	$300 / $900	$500 / $1,500	$3,000 Individual; $6,000 Family; combined in/out-of network; no coverage paid for any member of a family until $3,500 deductible is met	$0 / $0	$1,750 / $3,500	$0 / $0	$0 / $0
Annual Deductible (Individual/Family, Out of Network)	$500 / $1,500	$1,000 / $3,000	No Coverage	$3,300 / $6,600	No Coverage	No Coverage	No Coverage
Coinsurance Percentage (In Network)	80%	80%	80%	90%	90%	100%	100%
Coinsurance Percentage (Out of Network)	60%	60%	60%	No Coverage	70%	No Coverage	No Coverage
Out-of-pocket Maximum (Individual/Family, In Network)	$2,500 / $7,500	$3,000 / $9,000	$5,000 / $10,000	$1,000 / $3,000	$3,000 / $6,000	$1,500 / $3,000	$1,000 / $3,000
Out-of-pocket Maximum (Individual/Family, Out of Network)	$7,000 / $21,000	$6,000 / $18,000	$10,000 / $20,000	No Coverage	$6,000 / $12,000	No Coverage	No Coverage
Ability To Self-Refer to Specialists	Yes	Yes	Yes	Yes	Check guidebook	Check guidebook	

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

2027 Medical Plan Options Comparison of Benefit Coverages

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser	Kaiser Senior Advantage
Primary Doctor Office Visit	In Network - $25 copay	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	$25 copay	In Network - 90% covered after deductible is met	$25 copay	$25 copay
	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	No coverage Out-of-Network
Specialist Office Visit	In Network - $35 copay	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	$35 copay	In Network - 90% covered after deductible is met	$35 copay	$25 copay
	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	No coverage Out-of-Network
Preventive Care	In Network - 100% covered	In Network - 100% covered	In Network - 100% covered	100% covered	In Network - 100% covered	100% covered; for preventive	100% covered; for preventive
	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	No coverage Out-of-Network
Mammogram	In Network - Diagnostic: 80% after deductible is met; 100% covered for preventive care	In Network - Diagnostic: 80% covered after deductible is met; 100% covered for preventive care	In Network - Diagnostic: 80% covered after deductible is met; 100% covered for preventive care	Diagnostic: 90% covered; 100% covered for preventive care	In Network - Diagnostic: 90% covered after deductible is met; 100% covered for preventive care	100% covered for preventive care	100% covered for preventive care
	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	No coverage Out-of-Network
Immunizations (Child and adult)	In Network - 100% covered for preventive care	In Network - 100% covered for preventive care	In Network - 100% covered for preventive care	100% covered for preventive care	In Network - 100% covered for preventive care	100% covered for preventive care	100% covered for preventive care
	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	No coverage Out-of-Network

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

2027 Medical Plan Options Comparison of Benefit Coverages

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser	Kaiser Senior Advantage
Allergy Tests and Treatments	In Network - Diagnostic test/ diagnostic treatment: $25 copay PCP, $35 copay Specialist; allergy injections 100% covered	In Network - Diagnostic test/ diagnostic treatment: 80% covered after deductible is met; allergy injections 100% covered	In Network - Diagnostic test/ diagnostic treatment: 80% covered after deductible is met	Diagnostic test/diagnostic treatment: $25 copay PCP, $35 copay Specialist; allergy injections 100% covered	In Network - Diagnostic test/ diagnostic treatment: 90% covered after deductible is met	Diagnostic and testing: $25 copay per visit, allergy injections: $5 copay per visit	In Network - Diagnostic test/ diagnostic treatment: 90% covered after deductible is met
	Out of Network - Diagnostic test/ diagnostic treatment: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - Diagnostic test/diagnostic treatment: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - Diagnostic test/diagnostic treatment: 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - Diagnostic test/diagnostic treatment: 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	No coverage Out-of-Network
Outpatient X-ray and Laboratory Services	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	90% covered	In Network - 90% covered after deductible is met	100% covered	$25 copay; per procedure
	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	No coverage Out-of-Network
Outpatient Surgery	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	90% covered	In Network - 90% covered after deductible is met	$150 copay; per procedure	In Network - $25 per procedure
	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount; benefit limited to $350/visit	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	No coverage Out-of-Network
Outpatient Physical, Speech and Occupational Therapy	In Network - $25 copay; limited to 60 visits per year combined physical, speech and occupational therapy, in-network and out-of-network	In Network - 80% covered after deductible is met; limited to 60 visits per year combined physical, speech and occupational therapy, in-network and out-of-network	In Network - 80% covered after deductible is met; limited to 60 visits per year combined physical, speech and occupational therapy, in-network and out-of-network	$25 copay; limited to 60 visits per year combined physical, speech and occupational therapy	In Network - 90% covered after deductible is met; limited to 60 visits per year combined physical, speech and occupational therapy, in-network and out-of-network	$25 copay; per visit	$25 copay; per visit
	Out of Network - 60% covered after deductible is met; limited to 60 visits per year combined physical, speech and occupational therapy, in-network and out-of-network; subject to Maximum Allowed Amount limits	Out of Network - 60% covered after deductible is met; limited to 60 visits per year combined physical, speech and occupational therapy, in-network and out-of-network; subject to Maximum Allowed Amount limits	Out of Network - 60% covered after deductible is met; limited to 60 visits per year combined physical, speech and occupational therapy, in-network and out-of-network; subject to Maximum Allowed Amount limits	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; limited to 60 visits per year combined physical, speech and occupational therapy, in-network and out-of-network; subject to Maximum Allowed Amount limits	No coverage Out-of-Network	No coverage Out-of-Network
Fertility Services	In Network only - 50% covered after deductible is met; $20,000 lifetime maximum for all infertility benefits combined; medical and pharmacy	Not covered; IVF not covered	Not covered	In Network only - 50% covered; $20,000 lifetime maximum for all infertility benefits combined; medical and pharmacy	Not covered	Covered at 50% member rate; for diagnosis and treatment of involuntary infertility when approved by a Plan physician	Refer to EOC

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

2027 Medical Plan Options Comparison of Benefit Coverages

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser	Kaiser Senior Advantage
In-patient Hospital Services	In Network - $250 copay per admission; then 80% covered after deductible is met; $200 penalty if nonemergency services are not preauthorized	In Network - 80% covered after deductible is met; $200 penalty if nonemergency services are not preauthorized	In Network - 80% covered after deductible is met	$250 copay per admission; then 90% covered; $200 penalty if nonemergency services are not preauthorized	In Network - 90% covered after deductible is met	$500 copay per admission	$250 Copay Per Admission
	Out of Network - 60% covered after deductible is met; $200 penalty if nonemergency services are not preauthorized; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; $200 penalty if nonemergency services are not preauthorized; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	No Out-of-Network Coverage, unless medical emergency
Emergency Room (Not followed by admission)	In Network - $100 copay; then 80% covered after deductible is met; copay waived if admitted	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	In-Network - $100 copay; then 90% covered after deductible is met; copay waived if admitted	In Network - 90% covered after deductible is met	$100 copay; waived if admitted	$50 Copay; waived if admitted
	Out of Network - $100 copay then 80% covered after deductible is met; copay waived if admitted	Out of Network - 80% covered after deductible is met	Out of Network - 80% covered after deductible is met; non-emergencies subject to Maximum Allowed Amount	Out-of-Network - $100 copay for emergencies then 90% covered after deductible is met; copay waived if admitted	Out of Network - 90% covered after deductible is met	$100 copay; waived if admitted	Check with Plan
Urgent Care Clinic Visit	In Network - $25 copay	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	$25 copay	In Network - 90% covered after deductible is met	$25 copay; per visit	$25 Copay; Per Visit
	Out of Network - 60% covered; after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	$25 copay; per visit; non-Plan providers covered when outside the service area	Check with Plan
Ambulance Services	In Network - 80% covered after deductible is met; must be medically necessary	In Network - 80% covered after deductible is met; must be medically necessary	In Network - 80% covered after deductible is met; must be medically necessary	In Network - 90% covered; must be medically necessary	In Network - 90% covered after deductible is met; must be medically necessary	$50 copay per trip	$50 Copay Per Trip
	Out of Network - 80% covered after deductible is met; no copay if true emergency; must be medically necessary; subject to Maximum Allowed Amount	Out of Network - 80% covered after deductible is met; must be medically necessary; subject to Maximum Allowed Amount	Out of Network - 80% covered after deductible is met; must be medically necessary; subject to Maximum Allowed Amount	Out of Network - 90% covered; must be medically necessary; subject to Maximum Allowed Amount	Out of Network - 90% covered after deductible is met; must be medically necessary; subject to Maximum Allowed Amount		
Mental Health: Outpatient Coverage	In-network: 80% covered after deductible is met	In-network: Behavior Health visits, the deductible is waived; co-pay is $25.	In-network - Behavior Health visits, the deductible is waived; co-pay is $25.	In-network - $0 copay for visits 1-5; $25 copay for visits 6 and over	In-network - 90% covered after deductible is met	$25 copay individual visit; $12 copay group visit; unlimited visits	$25 Copay; Individual visit; $12 Copay group visit; Unlimited Visits
	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out-of-network - 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out-of-network - 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of- Network*	No coverage Out-of- Network*

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

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

2027 Medical Plan Options Comparison of Benefit Coverages

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser	Kaiser Senior Advantage
Mental Health: Inpatient Coverage	In-network: 80% covered after deductible is met	In-network: $25 copay with no deductible	In-network: 80% covered after deductible is met	In-network: 90% covered	In-network: 90% covered after deductible is met	$500 copay per admission	$250 copay per admission
	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	No Out-of-Network Coverage	Out-of-network: 70% covered after deductible is met; subject to Maximum Allowed Amount	No Out-of-Network Coverage	No Out-of-Network Coverage
Substance Abuse: Outpatient Coverage	In-network: 80% covered after deductible is met	In-network: $25 copay with no deductible	In-network: 80% covered after deductible is met	In-network: $0 copay for visits 1-5; $25 copay for visits 6 and over	In-network: 90% covered after deductible is met	$25 copay individual visit; $5 copay group visit; unlimited visits	$25 copay individual visit; $5 copay group visit; unlimited visits
	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	No Out-of-Network Coverage	Out-of-network: 70% covered after deductible is met; subject to Maximum Allowed Amount	No Out-of-Network Coverage	No Out-of-Network Coverage
Substance Abuse: Inpatient Coverage	In-network: 80% covered after deductible is met	In-network: 80% covered after deductible is met	In-network: 80% covered after deductible is met	In-network: 90% covered	In-network: 90% covered after deductible is met	$500 copay per admission; $100 copay for transitional residential recovery services; mental health/ chemical dependency services accrue to out-of-pocket minimum	$250 copay per admission; $100 copay for transitional residential recovery services; mental health/ chemical dependency services accrue to out-of-pocket minimum
	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	No Out-of-Network Coverage	Out-of-network: 70% covered after deductible is met; subject to Maximum Allowed Amount	No Out-of-Network Coverage	No Out-of-Network Coverage
Chiropractic/ Acupuncture	In Network - $25 copay; limited to 25 visits per calendar year	In Network - 80% covered after deductible is met; limited to 25 visits per calendar year	In Network - 80% covered after deductible is met; limited to 25 visits per year; combined in network and out-of-network	$25 copay; limited to 25 visits per calendar year	In Network - 90% covered after deductible is met; limited to 25 visits per year; combined in network and out-of-network	Get 20% off chiropractors, acupuncturists, and massage therapists using the Affinity Musculoskeletal program.	Get 20% off chiropractors, acupuncturists, and massage therapists using the Affinity Musculoskeletal program.
	Out of Network - 60% covered after deductible is met; limited to 25 visits per calendar year; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; limited to 25 visits per calendar year; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; limited to 25 visits per calendar year; combined in network and out-of-network; subject to Maximum Allowed Amount	No Out-of-Network Coverage	Out of Network - 70% covered after deductible is met; limited to 25 visits per calendar year; combined in network and out-of-network; subject to Maximum Allowed Amount	No Out-of-Network Coverage	No Out-of-Network Coverage

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

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

2027 Medical Plan Options Comparison of Benefit Coverages

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser	Kaiser Senior Advantage
Prescription Drug Vendor	Caremark	Caremark	Caremark	Caremark	Caremark	Kaiser	Kaiser
Member Services	1-866-623-1438	1-866-623-1438	1-866-623-1438	1-866-623-1438	1-866-623-1438	1-800-464-4000	1-800-464-4000
Website	www.caremark.com	www.caremark.com	www.caremark.com	www.caremark.com	www.caremark.com	https://choose.kp.org/llns	https://choose.kp.org/llns
Annual Prescription Drug Deductible	Not applicable	Not applicable	Medical deductible applies; member pays 100% of the Rx cost until medical deductible is met	Not applicable	Medical deductible applies; member pays 100% of the Rx cost until medical deductible is met	Not applicable	Not applicable
Prescription Drug Benefits are Covered Under Medical Deductible	No	No	Yes	No	Yes	Not applicable	Not applicable
Annual Rx Out-of-Pocket Maximum	$2,800 Individual; $5,700 Family (in- network only)	$2,100 Individual; $4,200 Family (in-network only)	Medical out-of-pocket maximum applies; once medical out-of- pocket maximum is met, Rx is 100% covered for the remainder of the calendar year	$3,500 Individual; $7,000 Family	Medical out-of-pocket maximum applies; once medical out-of-pocket maximum is met, Rx is 100% covered for the remainder of the calendar year	Not applicable	Not applicable
Retail Generic	In Network - $10 copay; 30 day supply Out of Network - 50% of average whole price schedule plus charges above the schedule	In Network - $10 copay; 30-day supply Out of Network - 50% of average whole price schedule plus charges above the schedule	In Network - 80% covered after deductible is met Out of Network - 60% covered after deductible is met	$10 copay; 30 day supply; Non- participating pharmacies: 50% of average whole price schedule plus charges above the schedule	In Network - 90% covered after deductible is met Out of Network - 70% covered after deductible is met	$15 for up to a 30-day supply; $45 for up to a 100-day supply; at Kaiser Pharmacy as prescribed by Plan Physician	$10 for up to a 30-day supply; $30 for up to a 100-day supply; at Kaiser Pharmacy as prescribed by Plan Physician
Retail Formulary Brand	In Network - 80% covered; $40 minimum copay, $60 maximum copay; 30 day supply Out of Network - 50% of average whole price schedule plus charges above the schedule	In Network - 80% covered; $40 min copay, $60 max copay; 30-day supply Out of Network - 50% of average whole price schedule plus charges above the schedule	In Network - 80% covered after deductible is met Out of Network - 60% covered after deductible is met	80% covered; $40 minimum copay, $60 maximum copay; 30 day supply; Non-participating pharmacies: 50% of average whole price schedule plus charges above the schedule	In Network - 90% covered after deductible is met Out of Network - 70% covered after deductible is met	$35 for up to a 30-day supply; $105 for up to a 100-day supply; at Kaiser Pharmacy as prescribed by Plan Physician	$25 for up to a 30-day supply; $75 for up to a 100-day supply; at Kaiser Pharmacy as prescribed by Plan Physician
Retail Nonformulary Brand	In Network - 60% covered; $60 minimum copay, $100 maximum copay; 30 day supply Out of Network - 50% of average whole price schedule plus charges above the schedule	In Network - 60% covered; $60 min copay, $100 max copay; 30-day supply Out of Network - 50% of average whole price schedule plus charges above the schedule	In Network - 80% covered after deductible is met Out of Network - 60% covered after deductible is met	60% covered; $60 minimum copay, $100 maximum copay; 30 day supply; Non-participating pharmacies: 50% of average whole price schedule plus charges above the schedule	In Network - 90% covered after deductible is met Out of Network - 70% covered after deductible is met	$35 for up to a 30-day supply; $105 for up to a 100-day supply; at Kaiser Pharmacy as prescribed by Plan Physician	Covered only when determined medically necessary by a plan physician. Note: Most specialty drugs have a 20% coinsurance (not to exceed $150) for up to 100-day supply.

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

2027 DENTAL PLAN OPTIONS COMPARISON*

	Delta Dental PPO	Deltacare DHMO (CA Only)
Member Services	1-800-777-5854	1-800-422-4234
Website	deltadentalins.com/llns	deltadentalins.com/llns
Network	Any licensed dentist; Delta Dental PPO Dentist provides higher benefit level	DeltaCare USA network of dentists
Annual Deductible: Individual/Family	In Network - $50 Individual; combined for both basic and major dentistry; waived for preventive/diagnostic care	$0 Individual; $0 Family
	Out of Network - $50 Individual; combined for both basic and major dentistry; waived for preventive/diagnostic care	Not applicable
Annual Maximum Coverage Per Person	Delta Dental PPO Dentist - $1,700	Not applicable
	Non Delta Dental PPO Dentist - $1,500	Not applicable
Preventive Care Benefits	In Network - 100% covered; sealants 80% covered	$0-$45 copays
	Out of Network - 100% covered of expected cost; sealants 75% covered	Not applicable
Annual Service Limits Preventive Care	In Network Cleaning: 2 per calendar year* Exams: 2 exams of any type per calendar year *3rd cleaning per calendar year provided for pregnant women	Cleaning and fluoride, one per 6 month period, child to age 19
	Out of Network - same as in network	Not applicable
Basic Services (fillings, routine extractions, endodontics, periodontics)	In Network - 80% covered after deductible is met	100% covered; for standard benefit; Copay for endodontics, periodontics
	Out of Network - 75% covered after deductible is met	Not applicable
Major Services (crowns, bridges, implants, dentures)	In Network - 50% covered after deductible is met	Copay applies
	Out of Network - 50% covered after deductible is met	Not applicable
Orthodontia Benefits	In Network - 50% covered	$1,700 - Child; $1,900 Adult; $100 Start Up Fee
	Out of Network - 50% covered	Not applicable
Service Limits and Maximums—Orthodontia	In Network - Limited to $1,500 per lifetime for dependent children; $500 per lifetime for adults	Check with plan
	Out of Network - Limited to $1,500 per lifetime for dependent children; $500 per lifetime for adults	Not applicable

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

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

2027 VISION PLAN OPTIONS COMPARISON*

	Vision Discount	Vision Choice Plan
Frequency (Exam/Lenses/Frame)	Once per calendar year (12/12/12)	12/12/12 January/January/January
Copay	$50 with purchase of complete pair of glasses; 20% without purchase	$10 exam/$25 materials
Diabetic Eyecare Plus	N/A	$20 copay per visit
Frames	25% savings when a complete pair of prescription glasses is purchased	$150 frame allowance
Lenses	With purchase of a complete pair of glasses: Single vision - $40; Lined bifocals - $60; Lined trifocals - $75	Covered after $25 materials Copay
Lens Enhancements	Average savings of 20-25% Progressive, Scratch-resistant, Anti-reflective coating, UV treatment	Standard progressive - $0; Premium progressive - $25; Polycarbonate - $31-35; Anti-reflective coating; UV treatment - $10-16
Contact Lenses	15% savings on contact lens exam (fitting and evaluation)	$130
Retinal Screening	Guaranteed pricing with exam, not to exceed $39	In Network - $10 copay; 30-day supply Out of Network - 50% of average whole price schedule plus charges above the schedule
Laser Vision Correction	Average 15% off the regular price or 5% off promotional price; discounts only available from contracted facilities	In Network - 80% covered; $40 min copay, $60 max copay; 30-day supply Out of Network - 50% of average whole price schedule plus charges above the schedule
Monthly Cost	$0	See rates on page 10

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

PLAN CONTACTS

Carrier / Plan	URL	Phone
Empyrean	www.llnsretireebenefits.com	(844) 750-5567
Via Benefits	http://www.viabenefits.com/	(866) 682-4841
Medicare	www.medicare.gov	(800) 633-4227
Social Security Administration	www.ssa.gov	(800) 772-1213
Kaiser Permanente CA	https://choose.kp.org/llns	(800) 464-4000
Kaiser Senior Advantage	https://choose.kp.org/llns	(800) 443-0815
Kaiser HRA	www.kp.org/healthpayment	(877) 761-3399
Anthem Blue Cross EPO	www.anthem.com/ca/llns	(866) 641-1689
Anthem Blue Cross PLUS	www.anthem.com/ca/llns	(866) 641-1689
Anthem Blue Cross PPO	www.anthem.com/ca/llns	(866) 641-1689
Anthem Blue Cross Core Value	www.anthem.com/ca/llns	(866) 641-1689
Anthem Blue Cross HDHP	www.anthem.com/ca/llns	(866) 641-1689
CVS/Caremark	www.caremark.com	(866) 623-1438
Delta Dental PPO	www.deltadentalins.com/llns	(800) 777-5854
Delta Care DMO	www.deltadentalins.com/llns	(800) 422-4234
Vision Service Plan	www.vsp.com	(800) 877-7195
MetLife Legal	www.legalplans.com	(800) 821-6400
AD&D AIG		(877) 202-1346

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