LANS

Health & Welfare Benefit Plan for Retirees

Summary Plan Description

Effective June 1, 2006 – Revised September 1, 2008

IMPORTANT

This Summary Plan Description (SPD) is intended to provide a summary of the principal features of the LANS Welfare Benefit Plan for Retirees ("Plan"). Additional information about component Benefit Programs is found in the Benefit Program Materials referenced in **Appendix C.** The documents referred to in Appendix C 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 LANS or any affiliated company, or as a guarantee of any rights or benefits under the Plan. LANS, 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 Los Alamos National Laboratory (LANL) Benefits Office at (877) 667-1806 or (505) 667-1806 or e-mail benefits@lanl.gov. SPDs are also available electronically at *LANL Benefits Website for Retirees:* http://www.lanl.gov/worklife/benefits/retirees/.

Table of Contents

1. Introduction 1
General Information 1
Plan Details 1
LANS Benefits 1

2. Eligibility Requirements 2
Eligibility for Retiree Welfare Benefits 2
Eligible Family Members 3
Eligible Adults 3
Eligible Children 4
Qualified Medical Child Support Orders (QMCSOs) 5
No Duplicate Coverage 5
Documentation 5
Loss of Family Member Eligibility 6
Rehired Retirees with Medicare 6
Mandated Medicare – Your Responsibility 6

3. How to Enroll 7
Period of Initial Eligibility (PIE) 7
Annual Open Enrollment 8
When Coverage Begins 8
When Coverage Ends 8

4. Paying for Coverage 10
Changes to Coverage and Contributions 10
Retiree Contributions for Benefits 10
LANS Contributions for Benefits 10
Benefit Program Material 11
Provider Networks 11
Maternity Hospital Stays (Newborns' and Mothers' Health Protection Act) 11
Benefits for Mastectomy-Related Services (Women's Health and Cancer Rights Act) 12
No Pre-existing Conditions Limitations 12

6. Other Benefits 13
Benefit Program Material 13
Accident Benefits 13
Legal Benefit Program 13

7. Making Changes to Your Medical, Dental, or Legal Benefit Program Elections 14
Life Events 14
Consistency Requirements 14
Coverage and Cost Events 14
Special Enrollment Rights − Medical and Dental Coverage 15
Other Rules on Changing Coverage 15
Special Note Regarding Domestic Partner Coverage 16
More Life Event Information 16

8. Claims and Appeals Procedures 17
Health Benefit Claims and Appeals Procedures 17
Non-Health Benefit Claims and Appeals Procedures 20
9. Continuation of Health Care Coverage 22
COBRA Continuation Coverage 22
Conversion Privileges 25
Right to Individual Health Coverage 25
10. Coordination of Health Care Benefits 25
When You Have Other Coverage 25
Coordination of Benefits with Medicare 27
11. General Plan Provisions 28
Administration of Plan 28
Contributions and Premiums 28
Acts of Third Parties 29
No Estoppel of Plan 30
Misuse of Plan 30
Responsibility for Benefit Programs 30
Assignment of Benefits 31
LANS Use of Funds 31
Plan's Use of Funds 31
Workers' Compensation 32
Withholding of Taxes 32
12. Your Rights and Privileges under ERISA 33
Appendix A: Premium Contribution Arrangements 35
Appendix B: Surviving Family Members Welfare Benefits 37
Appendix C: Benefit Program Materials 42
Appendix D: Claim and Appeals Administration Information 44
Appendix E: Funding and Contract Administration Information 46
Appendix F: Customer Care Center and COBRA Administrator 47
Appendix G: Plan Administration Information 48

1. Introduction

General Information

This Summary Plan Description ("SPD") describes the health and welfare Benefit Programs sponsored by Los Alamos National Security, LLC ("LANS") and made available to eligible retirees of LANS through the LANS Welfare Benefit Plan for Retirees ("Plan"). For purposes of this Plan, retiree means an individual who meets the Eligibility Requirements in Section 2, below.

Please share this SPD with your family members.

LANS maintains the Plan to provide benefits for the exclusive use of its eligible retirees 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 federal law), domestic partners, children, and grandchildren who are related to an eligible retiree. 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 C, together with any updates (including any Summary of Material Modifications SMMs) and open enrollment materials, 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 eligibility information for surviving family members;
- Appendix C for a list of the Benefit Program materials;
- Appendix D and Section 8 for claim and appeals administration information;
- Appendix E for funding and contract administration information;
- Appendix F for the Customer Care Center and COBRA Administrator; and
- Appendix G for Plan administration information.

LANS Benefits

Some of the Benefit Programs that may be offered by LANS from time to time as listed in Appendix C are:

- Medical (including prescription drug coverage),
- Dental,
- Legal, and
- Accidental death and dismemberment (AD&D).

Keep Your Records Updated

Make sure that LANS always has your current home address and telephone number to correctly administer your benefits and to send you benefits information.

Please notify the Customer Care Center in Appendix F to update your personal information, such as your home address and home telephone number.

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 eligibility for retiree welfare benefits.

Eligibility for Retiree Welfare Benefits

To qualify for Plan benefits (medical, dental, legal, AD&D), you must meet the rules in one of the following categories and all other applicable requirements:

A. Be a former employee of the University of California (UC) at Los Alamos National Laboratory (LANL) (or current or surviving family member of such former UC-LANL employee) who is receiving or is eligible to receive retiree welfare benefits from UC on May 31, 2006; or

B. Be a former employee of UC at LANL who terminated from UC before June 1, 2006, and who, within 120 days of termination from UC, elected to receive a monthly pension from the University of California Retirement Plan (UCRP); or

C. Be a former employee of LANS who is a UC Transitioning Employee[1] who properly elected TCP1, and who is vested with 5 years of Service Credits[4] and is eligible to receive a monthly disability benefit under the LANS Defined Benefit Eligible Disability Program and who applies for LANS welfare benefits within 120 days of termination from LANS; or

D. Be a former LANS employee who retires from a benefits eligible appointment at LANS on or after June 1, 2006, and who applies for LANS welfare benefits within 120 days of termination from LANS, *and who* is

   1. a UC Transitioning Employee[1] who properly elected TCP1 and is receiving a monthly pension from the LANS Defined Benefit Pension Plan; or

   2. a UC Transitioning Employee[1] who properly elected TCP2 who is receiving a monthly pension from the UCRP; or

   Note: UC TRANSITIONING EMPLOYEES WHO ELECT A LUMP SUM FROM THE UNIVERSITY OF CALIFORNIA RETIREMENT PLAN ARE NOT ELIGIBLE FOR SUBSIDIZED LANS RETIREE HEALTH AND WELFARE BENEFITS UNDER ANY CIRCUMSTANCES. ELIGIBILITY FOR THE LANS ACCESS ONLY RETIREE MEDICAL BENEFIT REQUIRES AT LEAST 10 YEARS OF SERVICE WITH LANS BEGINNING JUNE 1, 2006

   3. a Direct Transfer Employee[2] hired on or after June 1, 2006; or

   4. a LANS employee hired on or after June 1, 2006 who is not a Direct Transfer Employee[2], a Direct Transfer Employee hired on or after June 1, 2006 who does not have 10 years of Service Credits based on work performed on Department of Energy Management or Operating, Environmental Management or other DOE Prime contracts as of June 1, 2006, or a UC Transitioning Employee with less than 10 years of service as of June 1, 2006 and who properly elected TCP2 will be eligible for Access Only medical coverage based on their combined LANS and UC/parent company service

For purposes of **B**. and **D**., above, to be eligible for retiree welfare benefits you must *also* either:

- be at least age 50 with at least 10 years of applicable Service Credits[4]; or
- have at least 5 years of applicable Service Credits[4] and meet the "Rule of 75."[3]

For purposes of **B., C.** and **D**. above, to be eligible for retiree medical, dental, or legal benefits, you must *also* have continuous coverage in the applicable benefit (which, with respect to medical and dental coverage, may include COBRA continuation coverage) in a LANS sponsored group medical, dental or legal Benefit Program from the date of termination to the date retiree benefits begin. You may apply for AD&D benefits by contacting the AD&D Benefit Program provider listed in Appendix E.

Service Credits[4] for *Eligibility* for Retiree Welfare Benefits

Category of Retiree	Service Credits for *Eligibility* for Retiree Welfare Benefits
A	Service Credits[4] are based on years of service with UC.
B	Service Credits[4] are based on years of service with UC.
C	Service Credits[4] are based on years of service with UC prior to June 1, 2006 on June 1, 2006, *and* years of service at LANS beginning June 1, 2006.
D.1	Service Credits[4] are based on years of service with UC prior to June 1, 2006, *and* years of service at LANS beginning June 1, 2006.
D.2	Service Credits[4] are based on years of service with UC frozen upon transfer to LANS on June 1, 2006, *and* years of service at LANS beginning June 1, 2006.
D.3	Service Credits[4] are based on years of service with LANS Parent Company and/or Affiliate frozen upon transfer to LANS on date of hire at LANS, *and* years of service at LANS beginning with date of hire at LANS. Service Credits with LANS Parent Company and/or Affiliate are based on years of work performed on Department of Energy (DOE) Management and Operating, Environmental Management and other DOE Prime Contracts with the LANS Parent Company and/or Affiliate (including predecessor contractors).
D.4	Service Credits[4] are based on years of service with LANS or LANS and UC/parent company as applicable

For information on Service Credits[4] for ***LANS Contributions*** to retiree welfare benefits, please see Appendix A.

[1] A UC Transitioning Employee means an employee of LANS who joined LANS on June 1, 2006, and was employed by the University of California (UC) on May 31, 2006, and did not retire from UC.
[2] A Direct Transfer Employee means an employee of LANS who transfers to LANS directly from UC (excluding UC-LANL), Bechtel, BWXT or The Washington Group (LANS Parent Companies) or directly from an Affiliate of a LANS Parent Company. An Affiliate of a LANS Parent Company is any company partially or fully owned by a LANS Parent Company.
[3] The Rule of 75 means your age plus Service Credits equal 75.
[4] Service Credits means years of service calculated by and transferred to LANS from any LANS Parent Company and/or, for service with LANS on or after June 1, 2006, years of service calculated by LANS generally based on the methodology used to calculate Credited Service under the LANS Defined Benefit Pension Plan (whether or not the employee is eligible for the LANS Defined Benefit Pension Plan).

Eligible Family Members

Family members may be eligible for health and welfare benefits as:

- the eligible family members of a retiree receiving retiree welfare benefits under this Plan; or
- the eligible surviving family members of certain employees, certain former employees (not retired) and certain retirees as set forth in Appendix B.

Throughout this SPD, the term "spouse" or "legal spouse" means spouse as defined by applicable federal law unless otherwise provided under the terms of a fully-insured Benefit Program.

Coverages for Family Members

Family members are eligible for medical, dental and legal coverage as long as they meet the requirements outlined in this section.

AD&D coverage is available only to you and your spouse or domestic partner.

Your family member(s) are eligible only for the Benefit Program(s) in which you have enrolled (except surviving family members). For medical and dental benefits, family members must be covered under the same Benefit Program as you (except surviving family members and in situations where one member is Medicare eligible and the other is not).

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 federal law; or
- your opposite-sex domestic partner, who was enrolled in LANS health and welfare benefits as of December 31, 2007, and is therefore considered a grandfathered opposite-sex domestic partner. (Coverage under LANS benefits for a grandfathered opposite-sex domestic partner must be uninterrupted or grandfathered eligibility status is lost)
- your same-sex domestic partner who meets the requirements in the LANS Declaration of Domestic Partnership; or
- your adult dependent relative who was eligible for UC welfare benefits as of December 31, 2003, and who, as of May 31, 2006, is on a list of Adult Dependent Relatives provided to LANS by UC.

In addition to yourself, you may have only *one* eligible adult family member enrolled in your LANS-sponsored retiree Benefit Programs.

For example, if you cover an adult dependent relative on your medical and dental Benefit Programs, you may not enroll your spouse in **any** LANS-sponsored Benefit Program.

Eligible Children

Children who meet the criteria below are eligible for medical, dental, and legal benefits.

Note that your disabled child aged 23 or older is still considered to be your eligible child and not an adult. You may enroll your domestic partner's child or grandchild even if you do not enroll your domestic partner; however, your domestic partner must meet the requirements in the LANS Declaration of Domestic Partnership.

Child	Eligibility	Must meet all applicable requirements
Natural, placed for adoption or adopted child	To age 23 [B]	▪ unmarried
Stepchild, grandchild, or step-grandchild	To age 23 [B]	▪ unmarried ▪ living with you ▪ supported by you or your spouse (50%+) ▪ claimed as a tax dependent by you or your spouse
Same-sex domestic partner's child or grandchild [A]	To age 23 [B]	▪ unmarried ▪ living with you ▪ supported by you or your domestic partner (50%+) ▪ claimed as a tax dependent by you or your domestic partner
Legal ward enrolled 1/1/95 or after	To age 18	▪ unmarried ▪ living with you ▪ supported by you (50%+) ▪ claimed as your tax dependent
Overage disabled child (except a legal ward) of retiree	Age 23 or older	▪ unmarried ▪ living with you if not your natural or adopted child ▪ enrolled in a UC or LANS group medical benefit program before age 23 with continuous coverage and the incapacity must have begun before age 23. (Exception: A new hire at LANS on or after June 1, 2006 who is not a UC Transitioning Employee[1] may enroll an overage disabled child without any prior continuous group medical coverage). ▪ once eligible, continuous coverage under a LANS 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 23, as determined by the medical carrier ▪ must be approved before age 23
Non-tax dependent overage disabled child (except a legal ward) of retiree	Age 23 or older	▪ Same as above except not claimed as your dependent for income tax purposes

[A] Domestic partner must meet the requirements in the LANS Declaration of Domestic Partnership.

[B] New Mexico residents may enroll eligible children in their dental Benefit Programs until age 25. (This does not apply to legal wards.)

Ineligible Persons

- If you elected a lump sum payment through the UCRP you are not eligible for LANS subsidized retiree welfare benefits.
- If you were an employee covered by a collective bargaining agreement, except as otherwise provided in such agreement.

Ineligible Family Members

Certain family members are not eligible to participate in LANS-sponsored Benefit Programs, unless they qualify as your adult dependent relative or eligible child. Ineligible family members include, but are not limited to:

- opposite-sex domestic partners (unless grandfathered)
- siblings,
- in-laws,
- cousins,
- former spouses,
- former domestic partners,
- foster children,
- your children's spouses/domestic partners, and
- grandchildren's spouses/domestic partners.

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 request to the Plan Administrator listed in Appendix G at no cost to you.

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

- were born out of wedlock,
- are not claimed as dependents on your federal income tax return, or
- do not live with you.

No Duplicate Coverage

Plan rules do not allow duplicate coverage. This means you may not be covered in any LANS-sponsored program as a retiree and as an employee or as an eligible family member of a LANS employee or retiree at the same time. If you are covered as a family member and then become eligible for LANS coverage yourself, you have two options. You can either waive the coverage and remain covered as another employee or retiree's dependent **or** make sure the LANS employee or retiree who has been covering you de-enrolls you from his or her LANS-sponsored program before you enroll yourself.

Family members of LANS retirees may not be covered by more than one LANS retiree's program coverage. For example, if a husband and wife are both LANS retirees, their children cannot be covered by both the husband and the wife.

If duplicate enrollment occurs, LANS 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.

Documentation

To verify eligibility for your family members, LANS and the insurance carriers and third party administrators may request documentation needed to verify the relationship, including but not

limited to birth certificates, adoption records, marriage certificates, verification of domestic partnership, and tax documentation.

In addition, LANS 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.

LANS reserves the right to de-enroll individuals and their family members for failing to provide documentation when requested. In addition, retirees will be responsible for employer contributions to and benefits paid by the Plan for ineligible coverage.

Loss of Family Member Eligibility

Whenever a family member loses eligibility to participate in LANS-sponsored Benefit Programs, it is your responsibility to de-enroll that family member from the Benefit Program within 31 days by contacting the Customer Care Center in Appendix F. If you do not, you are liable for any excess LANS costs and for any Benefit Program expenses incurred by the ineligible family member. Premiums will not be refunded retroactively if the retiree did not cancel or delete an ineligible family member in a timely manner. See "Ineligible Persons" in this section for more details.

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

Rehired Retirees with Medicare

If you return to work for LANS after retirement and are hired into a position eligible for medical benefits, your coverage as a retiree will be affected. For further information and assistance please call the LANL Benefits Office at (877) 667-1806 or (505) 667-1806.

Certain people with disabilities who are under age 65, and people of any age who have permanent kidney failure can become eligible for Medicare coverage 24 months after their Social Security Disability Income ("SSDI") benefits begin.

Mandated Medicare – Your Responsibility

Medicare is the federal health insurance program administered by the Centers for Medicare and Medicaid Services (CMS).

Medicare includes: Medicare Part A (hospital insurance), Medicare Part B (medical insurance), and Medicare Part D (prescription drug coverage).

Medicare Part A and Part B: LANS requires each retiree, disabled member, and enrolled family member who is eligible to enroll in Medicare Part A and Part B *when first eligible for Medicare.** If enrolled in Part B, you cannot cancel enrollment at some future date and remain covered under the Plan. Those who do not comply with this requirement will be terminated from coverage under the LANS medical benefit program and will not be eligible to re-enroll.

*Retirees who were retired from the University of California-LANL and age 65 as of June 30, 1990, are not subject to the requirement to be enrolled in Medicare Part A and B. Members of the Medicare Offset Group who are not enrolled in Medicare Part B must pay an additional amount which is subject to change from year to year.

Certain people with disabilities who are under age 65, and people of any age who have permanent kidney failure can become eligible for Medicare coverage 24 months after their Social Security Disability Income ("SSDI") benefits begin.

3. How to Enroll

Retirees

At the time you become eligible for retiree benefits, the Customer Care Center will mail to your home address information on how to enroll in retiree medical and dental benefits. Information on enrolling in Legal or AD&D benefits will be provided by the LANL Benefits Office at the time of termination.

It is your responsibility to complete your enrollment forms for retiree benefits within 31 days of your date of eligibility. Eligibility begins the first of the second month following the date of termination from LANS, or the date of retirement if within 120 days of your termination from LANS, whichever is later. If you do not wish to enroll in the Legal or AD&D Benefit Programs, you do not have to take any action and you will not be enrolled.

If you do not receive the enrollment information for medical or dental benefits, please contact the Customer Care Center in Appendix F. If you need information on enrolling in the Legal or AD&D Benefit Programs please contact the LANL Benefits Office at (877) 667-1806 or (505) 667-1806.

Period of Initial Eligibility (PIE)

A PIE is a time during which you and/or, as applicable, your eligible family members may enroll in LANS-sponsored retiree Benefit Programs.

A PIE starts on the first day of eligibility and ends 31 days later—for example, a PIE starts on the day you become eligible for retiree benefits or the day you marry.

Other Periods of Initial Eligibility

If you are not enrolled in a LANS-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). Enrollment is not automatic; you must enroll the new family member within 31 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 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 with the date the adoption is final. Coverage begins on the first day of the PIE in which you enroll the child.

90-Day Waiting Period for Medical Coverage. After you have first enrolled in retiree medical coverage under this Plan, if you miss your Period of Initial Eligibility (PIE), you may enroll your eligible family members in medical coverage at any time with a 90 consecutive calendar day waiting period that begins the day the completed enrollment form is received by the Customer Care Center. Coverage is effective after the 90 days have elapsed.

Declining Medical, Dental, or Legal Coverage. A retiree or surviving family member may decline enrollment in medical, dental, or legal coverage for yourself and/or your eligible family members because you have other group or individual coverage.

If you lose the other coverage involuntarily, you have an opportunity to re-enroll in LANS medical, dental, or legal coverage upon the occurrence of an Involuntary Loss of Other Coverage (ILOC). As described in Section 7, "Making Changes to Your Medical, Dental, or Legal Benefit Program Elections," you will have a new PIE in which to enroll in a LANS-sponsored medical, dental, or legal benefit program.

Your LANS enrollment must be submitted within 31 days of the ILOC.

In addition, you may apply for AD&D benefits at any time by contacting the AD&D Benefit Program provider listed in Appendix E.

Suspending Medical Coverage

You may suspend TCP1 Retiree medical coverage (even if you are a transitioning TCP2 retiree who qualifies for TCP1retiree medical coverage). You may not suspend Access Only TCP2 retiree medical coverage.

When LANS-sponsored medical coverage is suspended, it also suspends LANS-sponsored

medical coverage for all enrolled eligible family members, LANS Medicare Part B premium reimbursement (if any), and LANS employer medical benefit program contributions.

If a retiree or survivor is enrolled in a LANS-sponsored dental benefit program, that coverage will continue for the retiree or survivor and eligible family members.

To suspend LANS-sponsored medical coverage, a retiree or survivor must contact the Customer Care Center.

Once medical coverage is suspended, the retiree has the following opportunities to re-enroll in a LANS-sponsored medical benefit program:

- **Open Enrollment.** You may re-enroll in a LANS-sponsored medical benefit program during any future open enrollment period (usually held in November), whether or not you are covered by other medical coverage unless the other coverage is non-LANS Medicare Part D coverage. If you have non-LANS Medicare Part D coverage, you are not eligible for any LANS medical benefits. See Section 2, "Eligibility Requirements, Mandated Medicare – Your Responsibility." LANS-sponsored medical coverage is effective January 1 of the following year.
- **Involuntary Loss of Other Coverage (ILOC).** You may re-enroll in a LANS-sponsored medical benefit program as described in Section 7, "Making Changes to Your Medical, Dental, or Legal Benefit Program Elections." You will have a new PIE in which to enroll in a LANS-sponsored medical benefit program. Your LANS enrollment must be submitted within 31 days of the ILOC.

Annual Open Enrollment

If you are a current retiree, you may generally enroll for coverage, change your coverage level, or waive coverage during the annual open enrollment period. Open enrollment elections are effective at the beginning of the Plan Year, generally 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.

When Coverage Begins

The date coverage begins will depend on when you are enrolled for coverage under a Benefit Program, and the Benefit Program in which you are enrolled. In general, coverage under the Plan begins the first of the second month following the date of termination from LANS, or the date of retirement if within 120 days of your termination from LANS, whichever is later. For more information, review the applicable Benefit Program material listed in Appendix C.

When Coverage Ends

Retirees

Retiree coverage generally ends:

- the last day of the month in which you fail to make a required contribution,
- the last day of the month in which you become ineligible for coverage, or
- the date the Plan or Benefit Program terminates,

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

Dependents of Retirees

Coverage for dependents generally ends:

- the last day of the month in which you fail to make a required contribution,
- the last day of the month in which your dependent ceases to be eligible for coverage,
- the day retiree coverage ends, or
- the date the Plan or Benefit Program terminates,

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

HIPAA Certificate of Creditable Coverage

When your medical coverage ends, you will automatically receive a certificate of creditable coverage that:

- confirms that you had medical coverage under the Plan; and
- states how long you were covered.

If you become eligible for other medical coverage that excludes or delays coverage for certain pre-existing conditions, you can use this certificate to receive credit – against the new program's pre-existing condition limit – for the time you were covered by the Plan.

You may request an additional certificate from your medical Benefit Program listed in Appendix D at any time while covered and within 24 months after coverage ends.

4. Paying for Coverage

You and LANS share the cost of coverage under certain of the Benefit Programs, as described in Appendix A. LANS will inform you before you enroll of your share of the cost of coverage for the relevant time period. During that time period, you will pay that fixed portion of the cost and LANS pays the balance of the cost. Your portion of the cost varies according to your eligibility status, 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. For more information, please see the Benefit Program material listed in Appendix C for the benefits in which you are enrolled.

Changes to Coverage and Contributions

Premiums are paid in advance by direct payment to the Customer Care Center in Appendix F for medical and dental coverage and by direct payment to the legal and AD&D Benefit Programs listed in Appendix E.

If a change is made to retiree coverage for medical or dental as a result of a retiree's PIE before the 15th day of the month the retiree will be responsible for paying the new rate for coverage in that month. If the change is effective on or after the 15th of the month then the retiree will begin paying the new rate for coverage in the following month.

Refer to your legal and AD&D Benefit Programs for information about rate changes.

Retiree Contributions for Benefits

All retiree contributions for benefits are paid on an after-tax basis.

LANS Contributions for Benefits

LANS contributions for benefits are generally not taxable income to retirees.

Imputed income. However, LANS contributions for coverage for individuals who do not meet the criteria for tax-favored health benefits under the IRC will result in imputed income to you. The box below summarizes the federal rules for tax-favored benefits. For example, to receive tax-favored health benefits, your dependent children must qualify in either the category of "Qualifying Children" or "Qualifying Relative" and your domestic partner must qualify in the category of "Qualifying Relative." Special rules apply for divorced parents.

Please contact the LANL Benefits Office if you have questions concerning domestic partner, dependent child or other eligibility.

Federal Tax Rules For Tax-Favored Health Benefits

Individuals who are otherwise eligible for medical and dental Benefit Program coverage under this Plan also must satisfy the following criteria in order to receive tax-favored health benefits within the meaning of the Internal Revenue Code (IRC):

- "Qualifying Children". Qualifying Children are your children by birth, adoption, stepchildren, or foster children who:
  - are under age 19, or under age 24 in the case of a full-time student, on the last day of the calendar year; and
  - do not provide over one-half of their own support; and
  - have the same principal place of residence as you for more than six months of the year (temporary absences, such as for school, are treated as time at the same principal place of residence).
- "Qualifying Relatives". Qualifying Relatives include:
  - Your children (by birth, adoption, stepchildren or foster children) of any age who receive over half of their support from you and who do not meet the above "qualifying child" requirements with respect to any other person.
  - Individuals who share your residence as a member of your household, who receive over half of their support from you, and who do not meet the above "qualifying child" requirements with respect to any other person.

Please also see IRS Publication 502 for a discussion of the definition of a tax dependent. The publication is available at w*ww.irs.ustreas.gov/prod/forms_pubs.*

5. Health Program Information

The Plan includes health (e.g., medical and dental) programs.

Benefit Program Material

The Benefit Program material for the health program in which you are enrolled generally will be sent to you. If you don't receive this material, contact your health Benefit Program listed in Appendix E.

The Benefit Program material listed in Appendix C 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.

Information about your health program is available in the Benefit Program materials listed in Appendix C.

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 E.

Provider Networks

If you are enrolled in a health program that offers benefits through provider networks, a list of providers will be provided without charge after your coverage takes effect. If you do not receive a provider directory from your health program, please contact the health program at the address, phone number, or Web site listed in Appendix E.

Refer to the Benefit Program material in Appendix C 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 only if your provider participates in or is associated with a network that your health program uses. 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 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 LANS 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 your or your dependent's physician and may 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, please refer to the Benefit Program material for the medical program in which you are enrolled.

No Pre-existing Conditions Limitations

When you enroll in any LANS-sponsored medical or dental 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.

6. Other Benefits

Benefit Program Material

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

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

- eligibility to receive services;
- exclusions, limitations, and terms for obtaining coverage;
- cost sharing;
- 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
- 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 E.

Accident Benefits

Retirees of LANS are eligible for retiree-paid accidental death and dismemberment (AD&D), benefits if they meet the requirements described in Section 2, "Eligibility Requirements" and in the applicable Benefit Program material listed in Appendix C. If you have questions about the Benefit Program, please contact your Benefit Program directly, as listed in Appendix E.

Eligible retirees may elect to cover their spouses or domestic partners. In addition to eligibility, the Benefit Program material may describe the coverage, terms, limitations, and costs to you.

Legal Benefit Program

The LANS former employee-paid group legal benefit program provides basic legal services for eligible former employees and their eligible family members.

Employees who terminate employment with LANS at age 50 or more with at least 5 years of service enrolled in the legal program as an active employee, have the option to continue coverage by enrolling in the UltimateAdvisor legal program. Former employees must contact ARAG® within 31 days of retirement to request an enrollment form, coverage information, rates and details on how to enroll. Former employees who were not enrolled in the legal program on the date of retirement are not eligible to enroll. See Appendix E for ARAG® contact information.

For more information, review the Benefit Program material listed in Appendix C. If you have questions about the Benefit Program, please contact your Benefit Program directly, as listed in Appendix E.

7. Making Changes to Your Medical, Dental, or Legal Benefit Program 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. However, you may be able to change your elections between annual open enrollment periods if certain events occur, as further explained below.

You must contact the Customer Care Center in Appendix F within 31 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, 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, including establishment or termination of a domestic partnership or death of your domestic partner.
- **Number of dependents.** An event that changes your number of dependents, including birth, death, adoption, and placement for adoption.
- **Dependent status.** An event that causes your dependent to become eligible or ineligible for coverage because of age, student status, or similar circumstances.
- **Residence.** A change in the place of residence of you, your spouse or another dependent.

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.** 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.
- **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.

You must contact the Customer Service Center within 31 days of the 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.

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.

Coverage Events

If LANS adds, eliminates or significantly reduces a Benefit Program in the middle of the Plan year, or if LANS-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 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 LANS 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.
- 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 during the Plan year, you may make a corresponding election change. For example, you may elect another Benefit Program with similar coverage, or drop coverage if no similar coverage is available. 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.

Special Enrollment Rights − Medical and Dental Coverage

If you decline enrollment for medical and dental 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.

Involuntary Loss of Other Coverage (ILOC). 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 LANS coverage was previously offered to you; and
- You (or your dependents) lose other coverage because:
  - You or your dependent exhaust rights to COBRA coverage, or
  - The employer's contributions to the other coverage stop, or
  - You or your family member is no longer eligible under that plan. If you or your dependent loses other health coverage due to one of these conditions, you may enroll yourself and your eligible dependents in a LANS health plan within 31 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 enroll yourself, your spouse, and eligible dependent children in a LANS health plan within 31 days of the date you acquire the new dependent.

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

Other Rules on Changing Coverage

Medicare 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 or Medicaid.

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 eligible child. The order must have resulted from a divorce, legal separation, annulment, or change in legal custody, 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.

Lifetime Maximum. A retiree (or a family member) who reaches a lifetime maximum on all benefits under a non-LANS medical benefit is provided an opportunity to enroll self and family member in a LANS medical Benefit Program. A retiree (or family member) who reaches a lifetime maximum on all benefits under a LANS medical Benefit Program provides the retiree or family member an opportunity to transfer to another LANS medical Benefit Program.

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 domestic partner or your domestic partner's tax dependent.

More Life Event Information

Detailed information about Life Events and PIEs may be obtained from the Customer Care Center in Appendix FC.

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 in Appendix C for the claims procedure that the Claims Administrator will follow.

Any claim or appeal for a specific benefit shall be timely made as specified in the applicable Benefit Program Summary directly to the Claims Administrator for that specific benefit.

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 of the date the claim was incurred or as provided in the applicable insurance policy or administrative agreement. No action at law or in equity in any court or agency shall be brought to recover benefits under the Plan prior to the exhaustion of the applicable ERISA Claim and Appeal Procedures nor shall an action be brought at all unless it is brought within twelve (12) months after the date the Claims Administrator renders its final decision upon appeal or as provided in the applicable insurance policy or administrative agreement.

The claims procedures for each specific Benefit Program will be furnished automatically to you without charge. See Appendix C. If you do not receive the claims procedures please contact the Customer Care Center in Appendix F. If you do not receive the claims procedures for group legal or AD&D benefits, please contact the applicable Claims Administrator directly. See Appendix D for a list of Claims Administrators.

Health Benefit Claims and Appeals Procedures

Filing an Initial Claim

You must follow the claims procedures established by the health Benefit Programs (medical and dental). 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 C for details on filing claims. See Appendix D 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 E for information on which Benefit Programs as 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.

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 D.
- **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.
- **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.
- **Authorized Representative.** An individual authorized to act on your behalf in pursuing a claim or appeal 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 D.

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 D. 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, no 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, no 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, no 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 and provided 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 you respond to the request for additional information. The Claims Administrator will then notify you of the benefit determination within 15 days after your response is received.

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 within 180 days after your receipt of the notice of adverse decision. For a list of Claims Administrators, see Appendix D. 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 state or federal 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.) 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 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 and no 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 and no 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 and no 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 D, 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 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.

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 C for details on filing claims. See Appendix D 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 D.
- **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 D.

Notice of Adverse Decision

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

For the AD&D and Legal 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 D.

- **For the AD&D and Legal, 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 state or federal court).

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 AD&D and Legal 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 D, 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 Claims 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" in this document provides additional information on legal action you can take if you feel your right to a benefit has been improperly denied.

9. Continuation of Health Care Coverage

COBRA Continuation Coverage

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, you or your dependents may be eligible to continue your health Benefit Program coverage (called “COBRA coverage”) at group rates. Health Benefit Program coverage includes medical and dental 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. LANS 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 group health coverage periodically changes. If you elect COBRA coverage, the COBRA Administrator will notify you of 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, or if the qualified beneficiary changes coverage level.

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 at least 30 days.

COBRA Administrator

If you have any questions about COBRA coverage or the application of the law, contact the COBRA Administrator listed in Appendix F.

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/ebsa.

Your Obligation to Notify the COBRA Administrator

You must notify the COBRA Administrator in writing immediately at the address listed below if:

- your marital status has changed;
- you, your spouse or a dependent has changed address; or
- a dependent loses eligibility for dependent coverage under the terms of the Plan.

All written notices and other communications regarding COBRA coverage for your health Benefit Programs should be directed to the COBRA Administrator listed in Appendix F.

Who is eligible for COBRA?

Spouses

If you’re the spouse (as defined under federal law) of a retiree 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; 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).

Dependent children

If you're a dependent child of a retiree 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 retiree (your parent) dies; or
- you cease to be a "dependent child" under the health Benefit Program; or

Chapter 11 Bankruptcy

In the unlikely event that LANS commences Chapter 11 bankruptcy proceedings in federal court, and you are a retiree, dependent child or spouse covered under a health Benefit Program on the day before the qualifying event, who loses coverage (including having your coverage substantially eliminated within one year before or after those proceedings commence), you have COBRA rights.

Continuation Coverage for Domestic Partners

Although continuation coverage for domestic partners and their dependents is not required by federal COBRA, LANS currently provides continuation coverage to domestic partners and their dependent children and grandchildren who were covered under the health programs when group coverage would otherwise have been lost. In the description of federal COBRA above, whenever the term:

- "Spouse" is used and wherever "qualified beneficiary" when referring to a spouse is used, the term "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 or grandchild/grandchildren 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

You must inform the COBRA Administrator 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 their 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 COBRA Administrator on a form which can be obtained by calling the COBRA Administrator. The notice should then be completed and provided to the COBRA Administrator at the address listed in Appendix F.

The notice must identify the qualified beneficiary requesting COBRA coverage and the qualifying event that gave rise to the individual's right to COBRA coverage. In addition, the qualified beneficiary may be required to provide the COBRA Administrator with documentation supporting the occurrence of the qualifying event.

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

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

LANS' 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 retiree dies; or
- LANS experiences a bankruptcy.

Electing COBRA

To elect or inquire about COBRA coverage, contact the COBRA Administrator listed in Appendix F.

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. A qualified beneficiary who doesn't choose COBRA coverage within the time period described above loses the right to elect COBRA coverage. The qualified beneficiary 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" refers to a current retiree 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.

Separate elections

Each qualified beneficiary has the right to elect COBRA coverage. This means that a dependent child can elect COBRA coverage even if the covered spouse chooses not to. A covered 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 the qualified beneficiary's retiree 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.

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

- you die;
- you divorce or legally separate;
- your dependent child loses eligibility for coverage; or
- in the unlikely event that LANS commences Chapter 11 bankruptcy proceedings in federal court, you will be eligible for COBRA coverage until your death, as long as LANS maintains any group health plan. Your covered surviving spouse and dependent children will be covered during that period, and will be entitled to an additional 36 months of COBRA coverage after your death.

Early termination of COBRA coverage

COBRA coverage will terminate before the expiration of the period described above for any of the following reasons:

- LANS no longer provides group health coverage to any of its employees; or
- the premium for COBRA coverage isn't paid on time (within the applicable grace period); or
- 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; or
- the qualified beneficiary first becomes entitled to Medicare after the date COBRA coverage is elected; or
- 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.

Benefit Program Changes During COBRA

While on COBRA coverage, there may be changes to the medical or dental Benefit Programs, such as new deductibles, covered expenses, or changes to your premiums. All

changes will also apply to your COBRA coverage.

HIPAA Certificate of Creditable Coverage

When your COBRA coverage ends, you will automatically receive a certificate of creditable coverage that:

- confirms that you had whatever medical coverage you continued through COBRA; and
- states how long you were covered.

If you become eligible for other medical coverage that excludes or delays coverage for certain pre-existing conditions, you can use this certificate to receive credit – against the new program's pre-existing condition limit – for the time you were covered by the Plan.

Conversion Privileges

Some health programs 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 LANS-sponsored insured medical program you may be able to apply for an individual medical policy from that program.

The coverage and benefits may not be the same as those provided by LANS-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 C.

Note: You also may be able to purchase an individual policy from an insurance carrier other than the provider for the LANS-sponsored 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 benefits 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 benefits.

Right to Individual Health Coverage

Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan;
- Your most recent coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

In addition to the certificate you receive automatically, you also may request an additional certificate from Benefits by calling (877) 667-1806 or (505) 667-1806 within 24 months after coverage ends.

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 LANS 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 Summary. See Appendix C.

If you do not receive the coordination of benefits procedures as a part of the Benefit Program material for medical or dental benefits, please contact the Customer Care Center in Appendix F.

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

Here's how it works in general:

- When the program pays first, in other words, if the LANS-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 LANS-sponsored program pays second, in other words, if the LANS-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 in which you are covered as other than a dependent (for example, as an active employee) rather than as a dependent is primary. If you also are a Medicare beneficiary and, as a result of federal law, a plan covering you as an active employee is primary, Medicare is secondary, and a plan covering you as a retiree determines benefits and pays last. If you are covered as a dependent of an active employee, and you are a Medicare beneficiary, the plan covering you as a dependent is primary, Medicare is secondary, and the plan covering you as a retiree (or as other than a dependent) determines benefits and pays last.
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 your child without specifying which parent is responsible to provide health coverage, LANS uses the "birthday rule" to determine which program pays benefits first when your 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 married or are living together, whether or not they were ever married, or are divorced, and your children are covered under both parents' programs, the birthday rule does not apply. Instead, LANS 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 you are 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 you are enrolled as an active employee or subscriber rather than as a COBRA participant is primary.
7. The program covering the individual 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 are eligible for Medicare, you must enroll in Medicare Part A and B and you may continue your medical coverage under a LANS program. Medicare will then be primary and pay benefits first for:

- Eligible retirees age 65 and over and spouses age 65 and over who participate in the LANS program on the basis of the retiree's former employment status with UC or LANS.
- Social Security disabled individuals who are covered by the LANS program on the basis of retiree's former employment status with UC or LANS 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, after the first 30 months of Medicare entitlement due to ESRD.

When, under the Medicare Secondary Payer rules Medicare is the primary payer, benefits payable under the LANS 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 and 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 LANS's 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.

[*] Retirees who were retired from the University of California-LANL and age 65 as of June 30, 1990, are not subject to the requirement that they be enrolled in Medicare Part A and B.

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

LANS 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 the Plan or any Benefit Program at any time. LANS' decision to amend or terminate is not a fiduciary decision. It is a business decision that can be made solely in LANS' interest.

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

Insured Benefits

Certain benefits under this Plan are fully insured. See Appendix E for information on which health 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 LANS.

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.

LANS does not assume 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 LANS, the Plan Administrator or any employee, officer or director of LANS.

Contributions and Premiums

LANS' Contributions

LANS may fund benefits provided under the Plan in whole or in part. Contributions made by LANS will be made at the times and in the manner determined by LANS. No assets will be set aside for the purpose of providing benefits under the Plan. LANS will pay benefits (including any insurance premiums necessary for the purchase of benefits) required under the Plan out of the general assets of LANS. In no event shall LANS 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. LANS 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 Plan.

Self Funded Benefits

LANS' general assets are the sole source of self-funded benefits under the Plan. LANS 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 LANS, 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 an equitable lien 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 – when an illness or injury is a result of a third party, you agree to place the funds in a separate, identifiable account and that the plan has an equitable lien on the funds, and/or 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.

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 to you that the Plan does not recover, if you do not provide the information, authorizations, or to 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 a Participating Employer or under any other plan, program or arrangement benefiting the employees or former employees of a Participating Employer, or otherwise recovering such overpayment from whoever has benefited from it.

Misuse of Plan

LANS reserves the right to de-enroll individuals and their family members who misuse the Plan. Misuse of the Plan includes, but is not limited to, actions such as falsifying enrollment or claims information, allowing others 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 C for details regarding the insurers' rules, which will govern if they conflict with the Plan rules.

Responsibility for Benefit Programs

Please note that:

- All service providers are independent contractors of the applicable program; LANS is not responsible for their actions.
- Neither the Plan Administrator nor LANS 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 LANS 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, LANS has not entered into an employment contract with any person. Nothing in the Plan documents gives any plan participant the right to be employed by LANS or to interfere with LANS' right to discharge any plan participant at any time. Similarly, these programs do not give LANS the right to require any employee to remain employed by LANS, or to interfere with an employee's right to terminate employment with LANS 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; neither you, 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 assign, sell, transfer, pledge, charge, encumber or allow the attachment or alienation of any such amount, whether presently or thereafter payable will be void. If you, your spouse, dependent, or beneficiary attempt to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber any amount payable under the Plan, or any part thereof, or if a person's bankruptcy or other event would cause amounts payable under the Plan to be subject to the person's debts or liabilities, then the Plan Administrator may direct that such amount be withheld and that the same or any part thereof be paid or applied to or for the benefit of you, your spouse (as defined under federal law) or your dependents, or any of them in such manner and proportion as the Plan Administrator may deem proper. Such payment shall constitute a complete discharge of the liability of the Benefit Program and the Plan.

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 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.

LANS Use of Funds

To the maximum extent permitted by applicable law, LANS 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 amounts paid to and held by the Plan (or any trust established in connection with the Plan), as well as any policy dividends and/or refunds not belonging to LANS, shall be available without limit to fund the benefits provided by any Benefit Program included in 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 or LANS contributions, or administrative fees) to reduce the level of contributions that LANS would otherwise make to the Plan for any Benefit Program. 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 LANS 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 and dental) 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," 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 COBRA Administrator located in Appendix F.

Reduce or Eliminate Exclusionary Periods

If you have creditable coverage from another medical program, you are entitled to a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group medical program. Your group medical program or health insurance issuer should provide a certificate of creditable coverage, free of charge, in the following instances:

- When you lose coverage under the program,
- When you become entitled to elect COBRA continuation coverage,
- When your COBRA continuation coverage ends,
- If you request it before losing coverage, or
- If you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 LANS, 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 a 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 a state or federal court if you have a claim for benefits which is denied or ignored, in whole or in part. You may file suit in a 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 a 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).

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 www.askebsa.dol.gov. 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/ebsa.

Additional Information

Additional pertinent information is attached as follows:

Appendix A: Premium Contribution Arrangements

Appendix B: Surviving Family Members Eligibility

Appendix C: Benefit Program Materials

Appendix D: Claim and Appeals Administration Information

Appendix E: Funding and Contract Administration Information

Appendix F: Customer Care Center and COBRA Administrator

Appendix G: Plan Administration Information

Appendix A: Premium Contribution Arrangements

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

<table>
<tr><th>ELIGIBILITY CATEGORIES A-D (See Section 2 for Eligibility Rules)</th><th colspan="2">LANS CONTRIBUTIONS TO RETIREE WELFARE BENEFITS</th></tr>
<tr><th>Service Credits[4] for LANS Contributions (if any)</th><th>Medical and Dental</th><th>Legal and AD&D</th></tr>
<tr><td>A. Be a former employee of the University of California (UC) at Los Alamos National Laboratory (LANL) (or current or surviving family member of such former UC-LANL employee) who is receiving or is eligible to receive retiree welfare benefits from UC on May 31, 2006.
Service Credits[4] are based on years of service with UC.</td>
<td rowspan="7"><u>Non-Medicare Eligible Retirees</u>
LANS contribution is determined by applying a service-based factor (“Service Credits”) to the maximum LANS contribution, as follows:
▪ 0-4 years of Service Credit - 0% LANS contribution.
▪ 5-9 of Service Credit
- if meet the Rule of 75 - 50% LANS contribution - if do not meet the Rule of 75 - 0% LANS contribution
▪ 10 years of Service Credit - 50% LANS contribution.
▪ 11-20 - 50% LANS contribution - increases in 5% increments, up to 100%.
<u>Medicare-Eligible Retirees</u>
If the LANS contribution is greater than the rate for the plan chosen by a Medicare-eligible retiree, then the difference can be used to pay for all or a portion of the Medicare Part B premium.
<u>Special Rules</u>
▪ UC Transitioning Employees[1] who properly elected TCP1 or TCP2 upon transfer to LANS, and who were hired in a career position with UC before January 1, 1990, and who have not had a break in service of more than 120 days, receive 100% of the LANS maximum contribution. The Rule of 75[3] does not apply.
▪ Retirees who, immediately before retirement, were receiving a monthly disability benefit under the LANS Defined Benefit Eligible Disability Program continue with a 50% LANS contribution even if they have less than 10 years of service. Upon retirement, the Service Credit earned while on disability status counts toward determining the percentage of the LANS contribution toward medical and dental coverage.
<u>Retiree Medical and Lump Sum Cash Out</u>
ANY election of a Lump Sum benefit from UCRP renders all prior service with UC/LANL inapplicable toward subsidized or Access Only Retiree health and welfare benefits.
Subsidized Medical – There is no possibility of subsidized through LANS if a Lump Sum Cashout option is exercised with UCRP.
Access Only – Only service on or after June 1, 2006 may be applied toward eligibility for Access Only coverage if a Lump Sum Cashout option is exercised with UCRP</td>
<td rowspan="7">No LANS contribution. Access only.</td></tr>
<tr><td>B. Be a former employee of UC at LANL who terminated from UC before June 1, 2006, and who, within 120 days of termination from UC elected to receive a monthly pension from the University of California Retirement Plan (UCRP).
Service Credits[4] are based on years of service with UC.</td></tr>
<tr><td>C. Be a former employee of LANS who is a UC Transitioning Employee[1] who properly elected TCP1, and who is vested with 5 years of Service Credits[4] and is eligible to receive a monthly disability benefit under the LANS Defined Benefit Eligible Disability Program and who applies for welfare benefits within 120 days of termination from LANS.
Service Credits[4] are based on years of service with UC frozen upon transfer to LANS on June 1, 2006, and years of service at LANS beginning June 1, 2006. The Rule of 75[3] does not apply.</td></tr>
<tr><td>D. Be a former LANS employee who retires from a benefits eligible appointment at LANS on or after June 1, 2006 and who applies for LANS welfare benefits within 120 days of termination from LANS, and who is</td></tr>
<tr><td>1. a UC Transitioning Employee[1] who properly elected TCP1 and is receiving a monthly pension from the LANS Defined Benefit Pension Plan; or
Service Credits[4] are based on years of service with UC frozen upon transfer to LANS on June 1, 2006, and years of service at LANS beginning June 1, 2006.</td></tr>
<tr><td>2. a UC Transitioning Employee[*] who properly elected TCP2 who is receiving a monthly pension from the UCRP; or
Service Credits[4] are based on years of service with UC frozen upon transfer to LANS on June 1, 2006.</td></tr>
<tr><td>3. a Direct Transfer Employee[2] hired on or after June 1, 2006; or
Service Credits[4] are based on years of service with LANS Parent Company and/or Affiliate frozen upon transfer to LANS on date of hire at LANS. Service Credits with LANS Parent Company and/or Affiliate are based on years of work performed on Department of Energy (DOE) Management and Operating, Environmental Management and other DOE Prime Contracts.</td></tr>
</table>

4. a LANS employee hired on or after June 1, 2006 who is not a Direct Transfer Employee[2], a Direct Transfer Employee hired on or after June 1, 2006 who does not have 10 years of Service Credits based on work performed on Department of Energy Management or Operating , Environmental Management or other DOE Prime contracts, or a UC Transitioning Employee with less than 10 years of service as of June 1, 2006 and who properly elected TCP2.	No LANS contribution. Access only.	

[1] A UC Transitioning Employee means an employee of LANS who joined LANS on June 1, 2006, and was employed by the University of California (UC) on May 31, 2006, and did not retire from UC.
[2] A Direct Transfer Employee means an employee of LANS who transfers to LANS directly from UC (excluding UC-LANL), Bechtel, BWXT or The Washington Group (LANS Parent Companies) or directly from an Affiliate of a LANS Parent Company. An Affiliate of a LANS Parent Company is any company partially or fully owned by a LANS Parent Company.
[3] The Rule of 75 means your age plus Service Credits equal 75. [4] Service Credits means years of service calculated by and transferred to LANS from any LANS Parent Company and/or for service with LANS on or after June 1, 2006, years of service calculated by LANS generally based on the methodology used to calculate Credited Service under the LANS Defined Benefit Pension Plan (whether or not the employee is eligible for the LANS Defined Benefit Pension Plan).

Appendix B: Surviving Family Members Welfare Benefits

Medical, Dental, and Legal Coverage

To be eligible for medical, dental and/or legal survivor benefits under this Plan, the surviving family member must have been enrolled in the medical, dental and/or legal benefit program under this Plan on the date of death of the Deceased.

Under certain circumstances, to be eligible, the surviving spouse or domestic partner must also be named as a Contingent Annuitant under either the UCRP or the LANS Defined Pension Plan, as applicable.

If the eligible surviving family member is not enrolled in the medical, dental and/or legal benefit program under this Plan on the date of death of the Deceased, the surviving family member must wait until an Involuntary Loss of Other Coverage (ILOC) to enroll in the benefit(s) in which he or she is not enrolled on the date of death. There is no later opportunity for enrollment at Open Enrollment.

Initially, coverage is limited to the benefit(s) (medical, dental and/or legal) in which the family member was enrolled on the date of death of the Deceased. However, if a benefit in which the family member is enrolled is offered during a subsequent Open Enrollment a surviving family member can change options within such benefit and add such eligible family members as may be permitted under this Appendix B.

Note: The adult family member who is enrolled at the date of death of the Deceased, is the *only* adult who will be eligible for LANS-sponsored coverage thereafter (for example, coverage may not be switched from the deceased's adult dependent relative to the surviving spouse). A surviving spouse or domestic partner may not enroll a new spouse or domestic partner in LANS-sponsored benefits, except for Accidental Death and Dismemberment (AD&D).

Please see footnotes below for definitions that apply to this Appendix B.

LANS Contribution toward Medical and Dental Premiums for Survivors

For surviving family members eligible for continued medical and dental coverage, the level of LANS maximum contribution is based on the Service Credits[3] of the Deceased as earned under the rules set forth in Section 2 and Appendix A of this SPD. The percentage corresponds to the Deceased's years of Service Credits[3] as shown below.*

Deceased's Years of Service Credit[3]	0–2	2–10	11	12	13	14	15	16	17	18	19	20+
Percentage of LANS Contribution	Not eligible	50%	55%	60%	65%	70%	75%	80%	85%	90%	95%	100%

*** Exceptions** to the LANS contributions set forth above: Eligible survivors of the following will receive 100% of the LANS maximum contribution toward the medical and/or dental premiums.

- A Retiree from the University of California (UC) at Los Alamos National Laboratory (LANL) whose membership in the UCRP began before January 1, 1990, without a break in service from the UCRP of more than 120 days;
- A LANS employee, disabled former employee, or retiree who is a UC Transitioning Employee[1] who properly elected **TCP1 who** dies at age 50 or more with at least 5 years of Service Credits[3] and whose membership in the UCRP began before January 1, 1990, without a break in service from either the UCRP or the LANS Defined Benefit Pension Plan of more than 120 days.

See *LANS Survivor Welfare Benefits Eligibility Chart* below for additional eligibility requirements.

LANS SURVIVOR WELFARE BENEFIT ELIGIBILITY CHART	
LANS CATEGORIES	**SURVIVING FAMILY MEMBERS WHO *MAY* BE ELIGIBLE FOR WELFARE BENEFITS** See Footnotes to Appendix B, below, for additional eligibility criteria.
Deceased Employee	
TCP1	
A current LANS employee who is a UC Transitioning Employee[1] who properly elected TCP1 who at any age with at least 2 but less than 5 years of Service Credits[3] and upon whose death the employee's family member(s) are eligible for the LANS Defined Benefit Survivor Income Benefit Program.	▪ Eligible Spouse[4] ▪ Eligible Domestic Partner[4] ▪ Eligible Child[4] ▪ Eligible Dependent Parent[4]
A current LANS employee who is a UC Transitioning Employee[1] who properly elected TCP1 who dies at age 50 or more with at least 5 years of Service Credits[3] and upon whose death the employee's family members are eligible for the LANS Defined Benefit Survivor Income Benefit Program.	▪ Surviving Spouse[4] ▪ Surviving Domestic Partner[4]
TCP2	
A current LANS employee who is a UC Transitioning Employee[1] who properly elected TCP2 who dies within 120 days of June 1, 2006, at age 50 or more with at least 5 years of Service Credits[3] and upon whose death the employee's family member is eligible for a survivor income under the UCRP.	▪ Surviving Spouse[4] ▪ Surviving Domestic Partner[4]

Deceased Former Employee	
TCP1	
A former LANS employee who is a UC Transitioning Employee[1] who properly elected TCP1 who dies within 120 days of termination from LANS at age 50 or more with at least 5 years of Service Credits[3] and whose surviving family members have had continuous coverage under LANS welfare benefits from the date of termination to the date of death.	▪ Surviving Spouse[4] ▪ Surviving Domestic Partner[4]
A former LANS employee who is a UC Transitioning Employee[1] who properly elected TCP1, who dies before age 50 with at least 5 years of Service Credits[3] and is eligible to receive a monthly disability benefit under the LANS Defined Benefit Eligible Disability Program and who applied for LANS welfare benefits within 120 days of termination from LANS and whose surviving family members have had continuous coverage under the LANS welfare benefits from the date of termination to the date of death and upon whose death the Employee's family members are eligible for the LANS Defined Benefit Survivor Income Benefit Program.	▪ Eligible Spouse[4] ▪ Eligible Domestic Partner[4] ▪ Eligible Child[4] ▪ Eligible Dependent Parent[4]
A former LANS employee who is a UC Transitioning Employee[1] who properly elected TCP1, and who dies at age 50 or more with at least 5 years of Service Credits[3] and is eligible to receive a monthly disability benefit under the LANS Defined Benefit Eligible Disability Program and who applied for LANS welfare benefits within 120 days of termination from LANS and whose surviving family members have had continuous coverage under the LANS welfare benefits from the date of termination to the date of death and upon whose death the Employee's family members are eligible for the LANS Defined Benefit Survivor Income Benefit Program.	▪ Surviving Spouse[4] ▪ Surviving Domestic Partner[4]

Deceased Retiree	
A former employee of the University of California (UC) at Los Alamos National Laboratory (LANL) who terminated from UC before June 1, 2006, upon whose death the spouse or domestic partner is eligible for a monthly survivor benefit from a pension plan due to service with LANL.	▪ Surviving Spouse[4] ▪ Surviving Domestic Partner[4]
A former LANS employee who terminated from a benefits eligible appointment at LANS on or after June 1, 2006, and who applies for LANS welfare benefits within 120 days of termination from LANS, *and who* is:	----
A UC Transitioning Employee[1] who properly elected TCP1, who is receiving a monthly pension from the LANS Defined Benefit Pension Plan and who, upon retirement properly elected a monthly pension with his or her spouse or domestic partner, as the case may be, designated as the Contingent Annuitant; *or*	▪ Surviving Spouse[4] ▪ Surviving Domestic Partner[4]
A UC Transitioning Employee[*] who properly elected TCP2 who is receiving a monthly pension from the UCRP and who, upon retirement properly elected a monthly pension and upon whose death the Retiree's surviving family members are eligible for a survivor income under the UCRP.	▪ Surviving Spouse[4] ▪ Surviving Domestic Partner[4]

Footnotes to Appendix B

[1] A UC Transitioning Employee means an employee of LANS who joined LANS on June 1, 2006, and was employed by the University of California (UC) on May 31, 2006, and did not retire from UC.

[2] A Direct Transfer Employee means an employee of LANS who transfers to LANS directly from UC (excluding UC-LANL), Bechtel, BWXT or The Washington Group (LANS Parent Companies) or directly from an Affiliate of a LANS Parent Company. An Affiliate of a LANS Parent Company is any company partially or fully owned by a LANS Parent Company.

[3] Service Credits means years of service calculated by and transferred to LANS from any LANS Parent Company and/or for service with LANS on or after June 1, 2006, years of service calculated by LANS generally based on the methodology used to calculate Credited Service under the LANS Defined Benefit Pension Plan (whether or not the employee is eligible for the LANS Defined Benefit Pension Plan).

[4] Definitions

Deceased

Deceased means, for purposes of this Appendix B, the Deceased Employee, Deceased Former Employee or the Deceased Retiree of UC or LANS, as applicable, as set forth in the *LANS Survivor Welfare Benefit Eligibility Chart* above, upon whose death certain eligible family members may be eligible for welfare benefits under this Plan.

Deceased Disabled

A participant in the LANS Defined Benefit Disability Benefit Program or a participant in the UCRP receiving disability benefits.

Disability

To determine eligibility as a disabled spouse, domestic partner, or child, disability is defined as a medically determinable physical or mental impairment which prevents the individual from engaging in "substantial gainful activity" on the basis of qualified medical opinion. "Substantial gainful activity" means any type of gainful activity commensurate with age, education skills or general background, which could reasonably be expected to result in earnings in excess of the Social Security Administration's annually published dollar amount used to determine substantial gainful activity ($860 per month in 2006).

Eligibility is determined by the Plan Administrator, and the spouse, domestic partner, or child must cooperate with all requests for information, including medical information. The disability must be expected to continue for an extended and uncertain period of time. For a disabled spouse or domestic partner, the disability must exist at the time of the Deceased's death. For a disabled child, the disability must have arisen while the child was otherwise eligible, i.e., under age 18, or under 22 and attending an educational institution on a full-time basis.

Eligible Child

The natural or adopted child or stepchild of a Deceased or the natural or adopted child of the Deceased's domestic partner. The child must have received at least 50 percent support from the Deceased for the one year period ending on: a) in the case of a Deceased Employee, the Deceased's date of death; b) in the case of a Deceased Disabled, the Deceased's disability date; or c) in the case of a Deceased Retiree, the Deceased's retirement date. On the date of the Deceased's death, the child must be:

- under age 18,
- under age 22 and attending an educational institution full time, or
- disabled (see "Disability" above); the disability must have occurred while the child was eligible based on age, as listed above.

The one-year support requirement does not apply to the Deceased's natural child born within 10 months after the Deceased's death or to the Deceased's natural child born less than one year before the Deceased's death. A stepchild or domestic partner's child must have been living with or in the care of the Deceased just before the Deceased's death.

Eligible Dependent Parent

The natural or adoptive mother or father of the Deceased who received at least 50 percent support from the Deceased for the one year period ending: a) in the case of a Deceased Employee, the Deceased's date of death; b) in the case of a Deceased Disabled, the Deceased's disability date; or c) in the case of a Deceased Retiree, the Deceased's retirement date.

Eligible Domestic Partner

The domestic partner of the Deceased established pursuant to the *LANS Declaration of Domestic Partnership*. The partnership must have been established for the one year period ending on: a) in the case of a Deceased Employee, the Deceased's date of death; b) in the case of a Deceased Disabled, the Deceased's disability date; or c) in the case of a Deceased Retiree, the Deceased's retirement date, and the partner must:

- be responsible for the care of an Eligible Child;
- be Disabled (see above); or
- have reached age 60.

If the domestic partner is responsible for the care of an Eligible Child who is the Deceased's natural child, the one-year domestic partnership requirement is waived.

If the Deceased was an employee or a disabled former employee eligible to retire (age 50 or more with at least 5 years of Service Credits[3]) or a retiree, the domestic partner may be eligible to receive benefits as a Surviving Domestic Partner; see below.

Eligible Spouse

The widow or widower of a Deceased. The date of the marriage must have been at least one year before: a) in the case of a Deceased Employee, the Deceased's date of death; b) in the case of a Deceased Disabled, the Deceased's disability date; or c) in the case of a Deceased Retiree, the Deceased's retirement date, and the spouse must:

- be responsible for the care for an Eligible Child;
- be disabled (see above); or
- have reached age 60. (The qualifying age is 50 for a widow if (a) the spouse and Deceased were married before October 19, 1973, and (b) the Deceased had entered UCRP by that date.)

If the spouse is responsible for the care of an eligible child who is the Deceased's natural child, the one-year marriage requirement is waived.

If the deceased was an employee or a disabled former employee eligible to retire (age 50 or more with at least 5 years of Service Credits[3]) or a retiree, the widow or widower may be eligible to receive benefits as a Surviving Spouse; see below.

Eligible Survivor

See "Eligible Spouse," "Eligible Domestic Partner," "Eligible Child," or "Eligible Dependent Parent."

Surviving Domestic Partner

The domestic partner of a Deceased established pursuant to the *LANS Declaration of Domestic Partnership*. The Surviving Domestic Partner is eligible to receive the survivor benefits without qualifying as an Eligible Domestic Partner under the following conditions:

- Deceased Employee —the Deceased must have been eligible to retire (age 50 or more with at least 5 years of Service Credits[3]) at the time of death.
- Deceased Disabled Former Employee—the Deceased must have been eligible to retire (age 50 or more with at least 5 years of Service Credits[3]) at the time of death.
- Deceased Retiree —the surviving domestic partner must have been in a relationship with the Deceased for at least one year before the Deceased's retirement date and continuously until the Deceased's death.

Surviving Spouse

The widow or widower of a Deceased. The Surviving Spouse is eligible to receive the survivor welfare benefits without qualifying as an Eligible Spouse under the following conditions:

- Deceased Employee —the Deceased must have been eligible to retire (age 50 or more with at least 5 years of Service Credits[3]) at the time of death.
- Deceased Disabled Former Employee —the Deceased must have been eligible to retire (age 50 or more with at least 5 years of Service Credits[3]) at the time of death.
- Deceased Retiree —the Surviving Spouse must have been married to the Deceased for at least one year before the Deceased's retirement date and continuously until the Deceased's death.

If Coverage Ends

If you were covered by LANS-sponsored welfare benefits, but you are *not* eligible for welfare benefits as a surviving family member, coverage stops on the last day of the last month for which premiums were paid.

You may be eligible to continue or convert your coverage.

Health coverage. For continuation of health care coverage options, please see Section 8.

Legal coverage. You may be able to convert your group legal coverage to an individual policy within 31 days of the date group coverage ends. Contact ARAG for more information. See Appendix E.

Appendix C: 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 herein by reference into the SPD and the Plan.

Medical	Benefit Program Material
Blue Cross	
Core New Mexico (Fee-for-Service) Retirees with Medicare Part A Only or Part B Only – Prescription Drug Benefits for Retirees with Medicare Part A Only or Part B Only	Benefit Program Summary http://www.lanl.gov/worklife/benefits/summaries.shtml
Core New Mexico (Fee-for-Service) Retirees with Medicare – Prescription Drug Benefits for Retirees with Medicare	Benefit Program Summary http://www.lanl.gov/worklife/benefits/summaries.shtml
Core New Mexico (BlueCard) Without Medicare	Benefit Program Summary http://www.lanl.gov/worklife/benefits/summaries.shtml
Core New Mexico (Prudent Buyer) In California Without Medicare	Benefit Program Summary http://www.lanl.gov/worklife/benefits/summaries.shtml
United HealthCare	
Options PPO New Mexico/Options PPO National (UHC)	Benefit Program Summary http://www.lanl.gov/worklife/benefits/summaries.shtml
Options PPO Out-of-Area (UHC)	Benefit Program Summary http://www.lanl.gov/worklife/benefits/summaries.shtml
Select EPO (UHC)	Benefit Program Summary http://www.lanl.gov/worklife/benefits/summaries.shtml
Behavioral Health – Substance Abuse*	
Options PPO New Mexico/Options PPO National (PacifiCare)	Benefit Program Summary http://www.lanl.gov/worklife/benefits/summaries.shtml
Options PPO Out-of-Area (PacifiCare)	Benefit Program Summary http://www.lanl.gov/worklife/benefits/summaries.shtml
Select EPO (PacifiCare)	Benefit Program Summary http://www.lanl.gov/worklife/benefits/summaries.shtml
Dental	Benefit Program Summary http://www.lanl.gov/worklife/benefits/summaries.shtml
Dental	Benefit Program Summary http://www.lanl.gov/worklife/benefits/summaries.shtml

Legal	
Legal Plan	Benefit Program Summary http://www.lanl.gov/worklife/benefits/summaries.shtml
Accidental Death & Dismemberment (AD&D)	
AD&D	Benefit Program Summary http://www.lanl.gov/worklife/benefits/summaries.shtml

*Offered as part of United HealthCare (UHC) medical benefit programs only.

Please contact your Benefit Program listed in Appendix E if you do not receive the Benefit Program Summary for the program in which you are enrolled.

Appendix D: 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
Medical	
Blue Cross of California Core New Mexico (Fee-for-Service) Retirees with Medicare Part A Only or Part B Only (Blue Cross) – Prescription Drug Benefits for Retirees with Medicare Part A Only or Part B Only (Blue Cross) Core New Mexico (Fee-for-Service) Retirees with Medicare (Blue Cross) – Prescription Drug Benefits for Retirees with Medicare (Blue Cross) Core New Mexico (BlueCard) Without Medicare (Blue Cross) Core New Mexico (Prudent Buyer) In California Without Medicare (Blue Cross)	BC Life & Health Insurance Company Post Office Box 6007 Los Angeles, CA 90060 1-800-759-3030 Http://www.bluecrossca.com/lans
United HealthCare Insurance Company Options PPO New Mexico/Options PPO National Options PPO Out-of-Area Select EPO	United HealthCare Insurance Company Post Office Box 30555 Salt Lake City, Utah 84130 1-800-603-3816 www.myuhc.com
PacifiCare Behavioral Health, Inc* Options PPO New Mexico/Options PPO National Options PPO Out-of-Area Select EPO	PacifiCare Behavioral Health, Inc. Claims Department Post Office Box 31053 Laguna Hills, CA 92654-1053 1-800-817-8811 www.pbhi.com
Dental	
Delta Dental of California	Delta Dental of California Post Office Box 997330 Sacramento, CA 95899-7330 1-800-777-5854 1-415-972-8300 www.deltadentalca.org/lans
Legal	
ARAG®	ARAG® Post Office Box 9171 Des Moines, IA 50309-9171 1-800–247-4184 http://members.araggroup.com/lans

*Offered as part of United HealthCare medical Benefit Programs only.

Benefit Program	Claims Administrator
Accidental Death & Dismemberment (AD&D)	
AIG Life Insurance Company	American International Companies Accident & Health Claims Division Post Office Box 15701 Rockwood Plaza Complex Wilmington, DE 19850-5701 1-800-551-0827 1-302-661-4176 www.aig.com

Appendix E: Funding and Contract Administration Information

Unless otherwise specifically indicated below, the Contract 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	TYPE OF FUNDING
Medical	
Blue Cross Core New Mexico (Fee-for-Service) Retirees with Medicare Part A Only or Part B Only – Prescription Drug Benefits for Retirees with Medicare Part A Only or Part B Only Core New Mexico (Fee-for-Service) Retirees with Medicare – Prescription Drug Benefits for Retirees with Medicare Core New Mexico (BlueCard) Without Medicare Core New Mexico (Prudent Buyer) In California Without Medicare Blue Cross of California 21555 Oxnard Street Woodland Hills, CA 91367	self-funded
United HealthCare Options PPO New Mexico/Options PPO National Options PPO Out-of-Area Select EPO United HealthCare Insurance Company 450 Columbus Boulevard Hartford, Connecticut 06115-0450	self-funded
PacifiCare* Options PPO New Mexico/ Options PPO National Options PPO Out-of-Area Select EPO PacifiCare Behavioral Health, Inc. 3120 Lake Center Drive Santa Ana, CA 92704-6917	self-funded
Dental	
Delta Dental of California 100 First Street San Francisco, CA 94105	self-funded
Legal	
ARAG® 400 Locust Street, Suite 480 Des Moines, IA 50309 800-247-4184 515-246-8710 fax Service@ARAGgroup.com	insured
Accidental Death & Dismemberment (AD&D)	
AIG Life Insurance Company Two Rincon Center 121 Spear Street San Francisco, CA 94105-1588G	insured

*Offered as part of United HealthCare medical Benefit Programs only.

Vision Plan	
Vision Service Plan (VSP) 3333 Quality Drive Rancho Cordova, CA 995670	insured

Appendix F: Customer Care Center and COBRA Administrator

Customer Care Center	Customer Care Center (866) 934-1200 www.ybr.com/benefits/lanl
COBRA Administrator	Customer Care Center (866) 934-1200 www.ybr.com/benefits/lanl

Appendix G: Plan Administration Information

Official Plan Name	LANS Welfare Benefit Plan for Retirees (See Appendix C for a listing of Benefit Programs applicable to this SPD).
Employer/Plan Sponsor	Los Alamos National Security, LLC P.O. Box 1663, MS P280 Los Alamos, NM 87545 (505) 664-0367
Employer I.D. Number (EIN)	20-3104541
Plan Number	502
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 LANS and the carriers. The carriers – not LANS – 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 are paid from the general assets of LANS.
Plan Administrator	Benefits and Investment Committee Los Alamos National Security, LLC TA-3 Otowi Building 261 2nd Floor PO Box 1663, Mail Stop P280 Los Alamos, NM 87544 (877) 667-0
Claims Administrator	See Appendix D
Agent for Service of Legal Process	Registered Agent Attention: LANS Counsel LANS, LLC 4200 West Jemez Road Suite 200B Los Alamos, NM 87545
Plan Year	Generally January 1 – December 31 (2006 Plan Year is June 1 – December 31)
Contribution Sources	LANS and participant contributions

LANS HR Benefits Design & Administration Group – September 1, 2008