LANS Health & Welfare Benefit Plan for Employees

Summary Plan Description

Revised January 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 Employees ("Plan"). Additional information about component Benefit Programs is found in Appendix B. The documents referred to in Appendix B 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 Employees* http://int.lanl.gov/worklife/benefits/.

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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 employees of LANS through the LANS Welfare Benefit Plan for Employees ("Plan"). For purposes of this Plan, employee 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 employees and their eligible dependents and beneficiaries.

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

The Benefit Program Materials referenced in Appendix B, together with any updates (including any Summary of Material Modifications (SMMs)) 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 a list of Benefit Program materials;
- Appendix C and Section 8 for claim and appeals administration information;
- Appendix D for funding and contract administration information; and
- Appendix E for Plan administration information.

LANS Benefits

LANS offers the Benefit Programs listed from time to time in Appendix B. Certain Benefit Programs may not be available to all LANS employees and dependents. Some of the Benefit Programs that may be offered from time to time are:

- Medical (including prescription drug coverage)
- Dental
- Vision
- Basic Life
- Core Life
- Supplemental Life
- Dependent Life
- Accidental death and dismemberment (AD&D)
- Short-term disability (STD)
- Supplemental disability
- LANS Defined Benefit Eligible Disability Program
- Business Travel Accident (BTA)
- Special Accident
- Legal
- Dependent Care Reimbursement Account (DCRA)
- Health Care Reimbursement Account (HCRA)
- Severance
- LANS Defined Benefit Eligible Survivor Income Program

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

Keep Your Records Updated

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

Go to LANL Worker Self Service online to update your personal information, such as your home address and home telephone number.

You may also send your updated information to:

Los Alamos National Security
LANL Benefits Office
P.O. Box 1663, MS P280
Los Alamos, NM 87545

2. Eligibility Requirements

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

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

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

Employee Eligibility

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

Initial Requirements

Full Benefits — Benefits Eligibility Level Indicator (BELI) 1

You are eligible to enroll in Full Benefits if you:

- are appointed to work one year or more; and
- are appointed to work 50% time or more; and
- hold one of the following appointment types:
  - regular full time (100% time),
  - regular part time (20 or more hours per week),
  - limited-term full time (100% time),
  - limited-term part time (20 or more hours per week),
  - post doc full time (100%),
  - post doc part-time (20 or more hours per week),
  - graduate research assistant (GRA) full time (100%),
  - graduate research assistant (GRA) part-time (20 or more hours per week),
  - undergraduate student (UGS) full time (100%) or
  - undergraduate student (UGS) part-time (20 or more hours per week).

You are also eligible to enroll in Full Benefits if you have worked 1,000 hours in a continuous 12-month period in BELI 2, 3, 4, or 5.

Mid-level Benefits—Benefits Eligibility Level Indicator (BELI) 2

You are eligible for Mid-level Benefits if you:

- are appointed to work at least one year or more (or your appointment ending date is for funding purposes only and your employment is intended to continue for more than a year); and
- are appointed to work 50 % or more time; and
- hold the following appointment type:
  - long term visiting staff member.

Mid-level Benefits—Benefits Eligibility Level Indicator (BELI) 3

You are eligible for Mid-level Benefits if you:

- are appointed to work 90 or more days, but less than one year; and
- are appointed to work 100% time; and
- hold one of the following appointment types:
  - limited-term full time,
  - long term visiting staff member,
  - graduate research assistant (GRA), or
  - undergraduate student (UGS).

Core Benefits—Benefits Eligibility Level Indicator (BELI) 4

You are eligible for Core Benefits if you:

- are appointed to work 89 days or less; and
- are appointed to work 100% time.

OR

- are appointed to work at least 90 days but not more than one year; and
- are appointed to work at least 43.75% but not more than 99% time.

No Benefits—Benefits Eligibility Level Indicator (BELI) 5

You are *not* eligible for benefits if you hold one of the following appointment types:

- casual,
- high school co-op, or
- laboratory associate.

Health and Welfare Benefit Programs

	Full Benefits	Mid-level Benefits	Core Benefits
Medical	x	x	
	or	*or*	
Medical – Core	x	x	x
Dental	x		
Vision	x		
Core Life		x	x
Basic Life	x		
Supplemental Life	x	x	
Dependent Life (Basic and Expanded)	x	x	
Accidental Death and Dismemberment (AD&D)	x	x	x
Short-Term Disability (STD)	x		
Supplemental Disability	x		
LANS Defined Benefit Eligible Disability Program	(certain UC Transitioning Employees[1] who properly elected TCP1 only)*		
Business Travel Accident, Global Travel, Corporate Aircraft Travel, War Risk Invalidation	x	x	x
Special Accident – Bomb Squad Accident Program, Field Deployment Team Accident Program	certain employees only*		
Legal	x	x	x
Health Care Reimbursement Account (HCRA)	x	x	x
Dependent Care Reimbursement Account (DCRA)	x	x	x
Severance	x	x	x
LANS Defined Benefit Eligible Survivor Income Program	(certain UC Transitioning Employees[1] who properly elected TCP1 only)*		

* See Benefit Program materials in Appendix B for eligibility for these benefits.

[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.

Continuing Requirements

LANS bases your ongoing eligibility for benefits on the number of regular hours you are paid by LANS to work each week. (Paid time excludes bonuses and overtime.)

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

If your average regular paid time drops below 17.5 hours a week, you become ineligible for all benefits.

Coverages for Family Members

Your family member(s) are eligible only for the Benefit Program(s) in which you have enrolled. For medical benefits family members must be covered under the same Benefit Program option as you.

Eligible Family Members

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

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

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

Surviving Family Members. For information on eligibility and benefits for surviving family members of certain employees, certain former employees and certain retirees, please see the *LANS Welfare Benefit Plan for Retirees Summary Plan Description*.

Eligible Adults

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

- your legal spouse as defined under applicable federal law; or
- your same-sex domestic partner who meets the requirements in the LANS Declaration of Domestic Partnership; or
- your opposite-sex domestic partner, who was enrolled in LANS health & welfare benefits as of December 31, 2007, and so considered as grandfathered opposite-sex domestic partners. Coverage under LANS benefits for a grandfathered opposite-sex domestic partner must be uninterrupted, or grandfathered eligibility status is lost.
- your adult dependent relative (ADR), who was eligible for UC health & welfare benefits as of December 31, 2003, and who, as of June 1, 2006, is on a list of grandfathered Adult Dependent Relatives provided to LANS by UC. Coverage under LANS benefits for a grandfathered adult dependent relative must be uninterrupted, or grandfathered eligibility status is lost.

In addition to yourself, you may have only *one* eligible adult family member enrolled in your LANS-sponsored 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, vision, dependent life, AD&D, and legal benefits. The eligibility rules for children under the LANS Defined Benefit Eligible Disability Benefit Program and the LANS Defined Benefit Eligible Survivor Income Benefit Program are different from those set forth here.

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 same-sex domestic partner's child or grandchild even if you do not enroll your same-sex domestic partner; however, your same-sex 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[2]	▪ unmarried
Stepchild, grandchild, or step-grandchild	To age 23[2]	▪ 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[1]	To age 23[2]	▪ unmarried ▪ living with you ▪ supported by you or your domestic partner (50%+) ▪ claimed as a tax dependent by you or your same-sex 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 employee	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[3] 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 or by the carrier during the Period of Initial Eligibility (PIE) for newly eligible employees
Non-tax dependent overage disabled child (except a legal ward) of employee	Age 23 or older	▪ Same as above except not claimed as your dependent for income tax purposes

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

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

[3] 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.

Ineligible Persons

Excluded Workers

Independent contractors and leased employees (that is, most temps) are not eligible to participate in the Plan. Any person who is not treated as a common law employee by LANS for income tax withholding purposes, regardless of any subsequent determination of such individual's legal employment status, will not be eligible to participate in the Plan.

Ineligible Family Members

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
- 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 E 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 an employee and 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'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 employees may not be covered by more than one LANS employee's program coverage. For example, if a husband and wife both work for LANS, their children cannot be covered by both family members.

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 B.

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. (See Section 11, General Plan Provisions, “Administration of Plan.”)

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, employees will be subject to disciplinary action and 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 online or by submitting a form available from LANL Benefits Office at (877) 667-1806 or (505) 667-1806. 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 employee did not cancel or delete a family member in a timely manner. See “Ineligible Persons” in this section for more details.

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

3. How to Enroll

Active Employees

If you're a new employee, you'll receive a packet of information, including a benefits election form, when you begin work at LANS. If you do not receive the packet and/or the form, please contact LANL Benefits Office at (877) 667-1806 or (505) 667-1806. You'll use the benefits election form to elect or waive your health coverage and other benefits. By electing to participate in one or more Benefit Programs offered under the Plan, you authorize LANS to deduct your share of the cost of your coverage from your pay. In the future, you will have the option of enrolling on-line.

No Default Enrollment in Core Health Benefits

If you are eligible for medical, dental or vision benefits and you fail to enroll, you will not be defaulted into Core medical, dental or vision benefits and you must wait until the next Open Enrollment or a PIE to enroll.

Period of Initial Eligibility (PIE)

A PIE is a time during which you and/or, as applicable, your eligible family members may enroll in certain LANS-sponsored Benefit Programs. Evidence of insurability (proof of good health) may be required.

A PIE starts on the first day of eligibility and ends 31 days later—for example, a PIE starts on the day you are hired into a position that makes you eligible for benefits.

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 same-sex 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*.** If you miss your Period of Initial Eligibility (PIE), you may enroll yourself or 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 Benefits. Coverage is effective after the 90 days have elapsed. Your premiums may need to be paid on an after-tax basis.

Annual Open Enrollment

If you are a current employee, you may generally enroll for coverage, change your coverage level, or waive coverage during the annual open enrollment period, which is usually held in November. However, certain benefits may not open to new enrollees every year, including, for example, the Disability programs and the Legal plan.

In addition, note that certain benefits require evidence of insurability (proof of good health) if you do not enroll when initially eligible and wish to enroll later. Open enrollment elections are effective January 1 of the following year. If you do not change your elections during open enrollment, your coverage levels will continue from the previous year with the exception of possible rate changes and contributions to the reimbursement accounts, which will terminate.

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

When Coverage Begins

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

If you are not initially eligible and later become eligible, coverage will be effective on the date of eligibility as long as you provide notice to Benefits within 31 days of the event.

When Coverage Ends

Active Employees

Active employee coverage generally ends:

- the last day of the month in which you terminate employment, or experience any other applicable qualified change in status
- the last day of the month in which you fail to make a required contribution,
- the last day of the month following lay-off,
- the last day of the month following the month in which you retire from LANS,
- 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 Employees

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 employee coverage ends, or
- the date the Plan or Benefit Program terminates,

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

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

Health Care Reimbursement Account (HCRA) coverage ends on the last day of the month following the date of termination or the effective date of a leave of absence other than an FMLA or a USERRA leave. (See the HCRA Benefit Program Summary for details on FMLA or USERRA leaves.) Following termination, HCRA coverage may be extended under COBRA or other continuation coverage. See Section 9 and the HCRA Benefit Program Summary for additional information on COBRA or other continuation coverage.

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 C 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. Your portion of the cost varies according to your benefits and coverage levels (i.e., single, family, etc.), and whether you are entitled to Full, Mid-level, or Core benefits. 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.

Contributions for Health Benefits

Pre-Tax Employee Contributions

Active employees generally pay their contributions for health benefits (includes medical, dental, and vision) on a “pre-tax” basis; that is, before federal income and employment taxes are deducted from their pay. This is referred to as Tax-Savings on Insurance Premiums, or “TIP.” In addition, contributions to the Health Care Reimbursement Account (HCRA) and the Dependent Care Reimbursement Account (DCRA) are on a pre-tax basis.

Paying for benefits on a pre-tax basis reduces your gross salary, which lowers your taxable income and, therefore, the amount of federal tax you must pay. In most states you also pay no state taxes on your contributions.

Paying for benefits on a pre-tax basis means that Social Security taxes will not be deducted for the pre-tax contribution. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these payments. This could result in a small reduction in the Social Security benefit you receive at retirement.

LANS Contributions

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

Imputed income

The value of coverage provided by LANS for individuals who are not considered dependents under the Internal Revenue Code must be considered as taxable income to the employee who enrolled the person. These "non-qualified dependents" include:

- same-sex and opposite domestic partners
- adult dependent relatives
- overage disabled dependents

Please contact the LANL Benefits Office if you have questions regarding non-qualified dependent status.

Salary Determination for Medical Premiums

Employer contributions towards medical plan premiums are determined based on predefined salary ranges by LANS. Base salary for the employee as of January 1st of the previous year or the date of hire, if the participant was not an employee as of January 1st of the previous year, is used to determine the salary range the employee is in.

Salary Determination for Medical Premiums Upon Rehire

If an employee is rehired by LANS within 120 days the employee's salary range remains that which was in effect prior to the break in service. If an employee is rehired after more than a 120 day break in service the salary range for medical plan contributions will be determined by using the employee's salary as of the employee's new date of hire.

Changes to Coverage and Contributions

Premiums are paid in advance by payroll deduction or salary reduction. There is no charge for the first full or partial month's coverage as a result of an employee's PIE or the first full or partial month's premium difference, if any, when a family member is added to the Benefit Program. This does not apply to open enrollment transfers between Benefit Programs. There is no charge for the first full or partial month's premium when an employee reenrolls during an added PIE provided there has been a lapse in coverage of more than one month.

When an employee terminates coverage in a Benefit Program, a family member is deleted, or a transfer between Benefit Programs is made, any premium adjustment is made on the first of the next month following the effective date of the change.

Employee Contributions for Other Benefits

Employee contributions for Legal, Supplemental Life, Supplemental Disability, Dependent Life, and AD&D insurance are paid on an after-tax basis.

Unpaid Leave of Absence

Employees on unpaid leaves of absence generally pay for coverage on an after-tax basis. If an employee is in pay status during the pay period in which an employer contribution would normally be paid towards medical, dental or vision coverage the employee will be eligible for that contribution. For example, since medical, dental and vision premiums are paid in advance, if an employee is in pay status in the last pay period of the month in which premiums are normally deducted for their following month medical, dental and vision coverage then their coverage with employer contributions will continue through the end of the following month.

If an employee begins unpaid leave earlier in the month and is not in a pay status in the last pay period of the month in which premiums are normally deducted the employee will be required to pay the full gross premium for the following month if required in accordance with the Leave of Absence policy. Thereafter, the amount of the premium to be paid by the employee who wishes to continue coverage while on unpaid leave will be determined based on rules found in the LANS Leave of Absence policy.

Health Care Benefits During Family Medical Leave Act (FMLA) Leave

LANS contributions for your health care benefits will continue during an approved leave without pay under the provisions of the federal Family and Medical Leave Act (FMLA) for up to 12 workweeks for the employee and any enrolled family members, provided the employee was enrolled in the respective Benefit Program at the beginning of the leave.

If you are receiving pay during an FMLA leave, your contribution, if any, for medical, dental, vision, and the Health Care Reimbursement Account will continue to be deducted from your pay. If you are not receiving pay during an FMLA leave, you may "pay as you go" on the same schedule that applied before your leave began. Payments will be made on an after-tax basis, if you are on unpaid leave.

You may revoke your health coverage elections and not have coverage during FMLA leave. In this case, when you return to work after the FMLA leave, you can be reinstated in the same benefits

you had before your FMLA leave unless there is an intervening Life Event or open enrollment.

For additional information on FMLA leaves, such as how to request a leave and other rights and obligations, as well as their impact on Plan benefits, please contact LANL Benefits Office at (877) 667-1806 or (505) 667-1806.

Short Term Disability

Employees receiving short term disability benefits will continue to receive the LANS contribution towards their medical plan coverage for up to 6 months provided their LANS employment is not terminated. These employees must arrange direct payment of any net premiums through the LANL Cashier's Office. Payment must be made in advance of each premium month.

The employee may not continue to cover a family member who loses eligibility. The employee must delete the family member from the plan within 60 days of ineligibility.

For more information on leaves of absence, refer to LANS' Leave of Absence policy.

5. Health Program Information

The Plan includes health (e.g., medical, dental, vision, and HCRA) 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 LANL Benefits Office at (877) 667-1806 or (505) 667-1806.

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

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

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

You may also obtain a copy of the Benefit Program material for the health program in which you are enrolled by contacting the program directly at the address or phone number listed in Appendix C. Or, you may contact LANL Benefits Office at (877) 667-1806 or (505) 667-1806.

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 C, or you may contact LANL Benefits Office at (877) 667-1806 or (505) 667-1806.

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

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

Generally, if you participate in a health program that provides benefits through a network of providers, benefits will be paid 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 you 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, dental, or vision 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 LANL Benefits Office at (877) 667-1806 or (505) 667-1806.

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

- eligibility to receive services;
- exclusions, limitations, and terms for obtaining coverage;
- 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; and
- procedures available for the review of denied claims.

You may also obtain a copy of the Benefit Program material for the program in which you are enrolled by contacting the program directly at the address or phone number listed in Appendix C. Or, you may contact LANL Benefits Office at (877) 667-1806 or (505) 667-1806.

Life, Disability, and Accident Benefits

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

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

Note that pre-existing conditions may limit the amount of benefits you can receive under the supplemental disability program. And, enrolling in or increasing coverage for supplemental and dependent life insurance and supplemental disability insurance outside of a period of initial eligibility (PIE) requires evidence of insurability (proof of good health).

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

Supplemental Life – Disability Waiver of Premium

If you are covered under Supplemental Life, become totally disabled (as defined in the applicable Benefit Program material) before age 65, and your disability continues for at least six consecutive months, you may qualify for continuance of life insurance protection without paying the premiums. You must provide written proof of your disability to the insurance carrier no later than one year after disability starts. Disability waiver of premium terminates at age 70. For information, contact LANL Benefits Office at (877) 667-1806 or (505) 667-1806.

Legal Program

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

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 termination to request an enrollment form, coverage information, rates and details on how to enroll. Former employees who are not enrolled in the legal program on the date of termination are not eligible to enroll. See Appendix D for ARAG® contact information.

Reimbursement Accounts

Health Care Reimbursement Account (HCRA)

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

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

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

Dependent Care Reimbursement Account (DCRA)

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

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

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

Important Note

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

Making Changes to Your Reimbursement Account Plan Elections

Qualified Life Event Changes

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

Severance Program

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

LANS Defined Benefit Eligible Disability Program

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

LANS Defined Benefit Eligible Survivor Income Program

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

7. Making Changes to Your Elections

In general, the Benefit Programs and coverage levels you choose when newly eligible and at open enrollment remain in effect through the end of the plan year. 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 Benefits 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 (or other applicable event) whichever occurs first.

Life Events

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

- **Legal marital status.** An event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, or annulment.
- **Same-sex 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 same-sex domestic partner.
- **Number of dependents.** An event that changes your number of dependents, including birth, death, adoption, and placement for adoption.
- **Employment status.** An event that changes you, your spouse's or your other dependent's employment status that results in gaining or losing eligibility for coverage. Examples include:
  - Beginning or terminating employment
  - Starting or returning from an unpaid leave of absence
  - A change in your appointment status that results in a change of Benefits Eligibility Level Indicator (BELI). (See Section 2, "Eligibility Requirements".)
  - Changing from part-time to full-time employment or vice versa
  - A change in worksite
- **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.** Except for the DCRA, the Life Event must affect eligibility for coverage under the Plan or under a plan sponsored by the employer of your spouse or other dependent. For this purpose, eligibility for coverage is affected if you become eligible (or ineligible) for coverage or if the Life Event results in an increase or decrease in the number of your dependents who may benefit from coverage under the Plan.

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

  For life insurance and disability insurance coverages, an election to increase or decrease coverage in response to a Life Event is considered to correspond with the event.

You must contact Benefits 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. *You are not permitted to make a change to your HCRA due to coverage and cost events.*

Coverage Events

If LANS adds, eliminates or significantly reduces benefits offered under 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 substantially reduce coverage to participants in general, participants enrolled in that Benefit Program may revoke their election and elect coverage under another option providing similar coverage.
- If LANS adds another Benefit Program mid-year, participants can drop their existing corresponding 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. This rule applies to the DCRA as well as medical, vision, and dental coverage.
- If another employer's plan (for example, your spouse's employer) allows you, your spouse or your dependent child to change his or her elections in accordance with IRS regulations, you may make a corresponding mid-year election change to your coverage.

Cost Events

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

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

The Plan Administrator will determine whether a change in cost is significant.

Dependent Care Reimbursement Account

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

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

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

Special Enrollment Rights – Medical, Dental, or Vision Coverage

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

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

- You (or your dependents) were covered under other health coverage when LANS coverage (for example, under another employer's medical plan) 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 dependent 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 or Medicaid Entitlement. You may, but are not required to, change an election for medical coverage mid-year if you, your spouse, or dependent becomes entitled to Medicare or Medicaid coverage. However, you're limited to reducing your coverage only for the person who becomes entitled to Medicare or Medicaid, and you're limited to adding coverage only for the person who loses eligibility for Medicare or Medicaid.

Family and Medical Leave Act. You may revoke an election for health coverage mid year (including the HCRA) when you begin a leave, subject to the provisions of the Family and Medical Leave Act (FMLA). If you revoke coverage or if you fail to make payments during your FMLA leave, when you return from the FMLA leave, except with respect to HCRA, you will be reinstated to the same elections you made prior to taking your FMLA leave. With respect to HCRA please refer to the HCRA/DCRA Benefit Program Summary referenced in Appendix B for more information.

Judgment, Decree, or Order. You may revoke an election for health coverage mid-year and make a new election if a judgment, decree, or order requires health coverage for your child, including a foster 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. An employee (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. An employee (or family member) who reaches a lifetime maximum on all benefits under a LANS medical Benefit Program is provided an opportunity to transfer to another LANS medical Benefit Program.

Special Note Regarding Same-sex 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 same-sex domestic partner or your same-sex domestic partner's tax dependent. Therefore, you may add or drop a same-sex domestic partner from coverage during the year if the partner has a qualifying event. However, IRS rules generally do not permit you to make a mid-year change with respect to your own coverage election for the year for such events unless they involve a tax dependent.

Therefore, you cannot make a change to your election for the Plan year even if your same sex domestic partner is permitted to add or drop coverage during the year unless the same sex domestic partner is also your tax dependent

See Section 4. for more information on who qualifies as a federal tax dependent.

More Life Event Information

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

8. Claims and Appeals Procedures

Important Note

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

Any claim or appeal for a specific benefit shall be made in accordance with the applicable insurance policy or administrative agreement directly to the Claims Administrator for that specific benefit. See Appendix C for Claims Administrators.

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

A claim for benefits must be filed within twelve (12) months from the date the claim was incurred or as provided in the applicable 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 B If you do not receive the claims procedures please contact the LANL Benefits Office at (877) 667-1806 or (505) 667-1806 or e-mail benefits@lanl.gov.

Health Benefit Claims and Appeals Procedures

Filing an Initial Claim

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

Appeals Procedures

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

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

Definitions

- **Claim.** Any request for program benefits made to the proper person in accordance with the program's claims filing procedures, including any request for a service that must be pre-approved. Claims must be submitted in writing to the appropriate Claims Administrator listed in Appendix C.
- **Urgent Care Claim.** Any claim for health care or treatment that has to be decided more quickly because the normal timeframes for decision-making could seriously jeopardize your life or health or your ability to regain maximum function, or in the opinion of a physician with knowledge of your condition, subject you to severe pain that can't be adequately managed without the care or treatment addressed in the claim.
- **Pre-Service Claim.** Any claim for a health benefit – other than an Urgent Care Claim – that must be approved in advance of receiving medical care (for example, requests o pre-certify a hospital stay or for pre-approval under a utilization review program).

- **Post-Service Claim.** Any other type of health claim, including a claim for reimbursement through the Health Care FSA.
- **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 C.

Insufficient Claims

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

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

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

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

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

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

Notice of Benefit Determination

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

The timeframes for providing notice of a benefit determination generally start when a written claim for benefits is received by the Claims Administrator. Notice of a benefit determination may be provided in writing by hand delivery, mail, or electronic delivery. However, in some urgent cases, you may first be provided notice orally, which will be followed by written or electronic

notice within three calendar (not business) days. The timeframes for providing a notice of benefit determination are as follows:

- **Urgent Care Claims.** As soon as possible considering the medical urgency, 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 C. 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.) If requested by the claimant, the Claims Administrator will provide for the

identification of medical or other experts whose advice was obtained in considering the original decision on your claim, whether or not the Claims Administrator relied on their advice.

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

- was relied upon in making the decision on your claim or appeal;
- was submitted to, considered, or generated by the 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 B for details on filing claims. See Appendix C for a list of claim administrators and their contact information.

Appeals Procedures

Definitions

- **Claim.** A request for program benefits made to the proper person in accordance with the Claims Administrator's claims filing procedures. Claims must be submitted in

writing to the appropriate Claims Administrator listed in Appendix C.

- **Adverse Decision or Adverse Decision on Appeal.** A denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a benefit.
- **Authorized Representative.** An individual authorized to act on your behalf in pursuing a claim or appeal, in accordance with procedures established by the Claims Administrator. For information about appointing an authorized representative, contact the Claims Administrator listed in Appendix C.

Notice of Adverse Decision

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

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

Appeal of Adverse Decision

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

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

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

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

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

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

Notice of Decision on Appeal

- **For the Disability programs**, the Claims Administrator will provide notice of its decision within 45 days after the date you file the appeal with the Claims Administrator. The Claims Administrator may extend the decision-making period for up to 45 days if special circumstances require extra time. You will be notified of the extension prior to the end of the first 45-day period.
- **For the Life, AD&D, Legal, Severance, and Survivor Income Benefits programs,** the Claims Administrator will provide notice of its decision within 60 days after the date you file the appeal. The Claims Administrator may extend the decision-making period for up to 60 days if special circumstances require extra time. You will be notified of the extension prior to the end of the first 60-day period.

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

Your Right to Information

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

- was relied upon in making the decision on your claim or appeal;
- was submitted to, considered, or generated by the 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.)

The section, "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

Federal COBRA Continuation Coverage

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

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 any changes in the cost. Premiums are established in a 12-month determination period and will increase during that period if the Plan has been charging less than the maximum permissible amount, if the qualified beneficiary changes coverage level, or in the case of a disability extension.

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

COBRA Administrator

The COBRA Administrator is the Plan Administrator. If you have any questions about COBRA coverage or the application of the law, contact LANL Benefits Office at (877) 667-1806 or (505) 667-1806.

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 or domestic partner status has changed;
- you, your spouse, same-sex domestic partner 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 and your health Benefit Programs must be submitted on the appropriate forms within applicable deadlines as set forth in more detail throughout this section. You can obtain the required forms from the LANL Benefits Office or from http://www.lanl.gov/worklife/benefits/forms.shtml

Notices must be sent to:

LANL Benefits Office
P.O. Box 1663 MS P280
Los Alamos, NM 87545

Continuation Coverage for Same-sex domestic partners

Although any continuation of coverage for same-sex domestic partners and their dependents is not required by federal COBRA, LANS currently provides continuation of coverage to same-sex 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 "same-sex 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 same-sex domestic partner also generally applies.
- Wherever the term "divorce" is used, termination of same-sex domestic partnership also generally applies.
- Wherever the term "COBRA continuation coverage", is used, continuation coverage also generally applies.

Who is eligible for COBRA

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

If you're enrolled in a health Benefit Program and don't return to work following a leave of absence qualifying under the Family and Medical Leave Act (FMLA), the event that will trigger COBRA coverage is the date that you indicate you won't be returning to work following the leave or the last day of the FMLA leave period, whichever is earlier.

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

- your spouse dies;
- your spouse's employment is terminated (for reasons other than gross misconduct) or your spouse's hours of employment are reduced;
- 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); or
- your spouse becomes entitled to Medicare (Part A, Part B, or both).

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

- the employee dies;
- the employee's employment is terminated (for reasons other than the employee's gross misconduct) or the employee's hours of employment are reduced;
- the employee becomes entitled to Medicare (Part A, Part B or both); or
- you cease to be a "dependent child" under the health Benefit Program.

If the covered employee elects continuation coverage and then has a child (either by birth, adoption or placement for adoption) during that period of COBRA coverage, the new child is a qualified beneficiary. In accordance with the terms of the health Benefit Program and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage by providing a written notice to the COBRA Administrator of the new child's birth, adoption or placement for adoption at the address listed in Appendix C. This written notice should include information about the new child who will be receiving COBRA coverage. The COBRA Administrator may ask for documentation

supporting the birth, adoption or placement for adoption of the new child.

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

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 your 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 from the COBRA Administrator. To request a form, call the COBRA Administrator at (877) 667-1806 or (505) 667-1806. The notice should then be completed and provided to the COBRA Administrator at the address listed in Appendix C.

The notice must identify the employee or qualified beneficiary requesting COBRA coverage and the qualifying event that gave rise to the individual's right to COBRA coverage. In addition, the employee or qualified beneficiary may be required to provide the 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.

COBRA Admininstrator's duties

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

- the employee dies;
- the employee's employment is terminated (for reasons other than the employee's gross misconduct) or the employee's hours of employment are reduced;
- the employee becomes covered by Medicare (Part A, Part B, or both); or
- LANS experiences a bankruptcy.

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

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

Electing COBRA

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

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

If you choose COBRA coverage, your coverage will be the same coverage you had immediately before the event and the same coverage that is being provided to similarly situated beneficiaries. "Similarly situated" generally refers to a current

employee or dependent who hasn't had a qualifying event.

You'll have the same opportunity to change health Benefit Program coverage as similarly situated active employees have, e.g., at annual open enrollment or if you gain a new dependent. This also means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified.

Separate elections

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

Length of COBRA coverage

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

The maximum duration of COBRA coverage depends on the reason you or your covered dependents are eligible for COBRA coverage.

If group health coverage ends because of your termination of employment or reduction in hours, COBRA coverage may continue for you and your covered spouse and dependents for up to 18 months.

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

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

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

Note that COBRA coverage for the Health Care FSA ends at the end of the Plan year in which the qualifying event occurs.

Disability extension

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

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

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

Second qualifying event extensions

Your spouse (as defined under federal law) and dependents may have additional qualifying events while they are covered by COBRA. These

events can extend their 18-months (or 29 months) continuation period to 36 months, but in no event will they have more than 36 months of COBRA measured from the first day of the month following the first qualifying event that originally allowed them to elect coverage. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the additional event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

The law requires a qualified beneficiary to notify the COBRA Administrator if any of these additional qualifying events occur. This notice must be provided within 60 days from the latest of (1) the date of the second qualifying event, or (2) the date coverage would have been lost because of the event.

Notice of the additional qualifying event must be provided to the COBRA Administrator on the appropriate form, which may be obtained from the COBRA Administrator. The form should be returned to the COBRA Administrator at the address shown in Appendix C.

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

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

Early termination of COBRA coverage

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

- LANS no longer provides group health coverage to any of its employees;
- the premium for COBRA coverage isn't paid on time (within the applicable grace period);
- the qualified beneficiary becomes covered – after the date COBRA coverage is elected – under another group health plan that doesn't contain any applicable exclusion or limitation for any pre-existing condition of the individual;
- the qualified beneficiary first becomes entitled to Medicare after the date COBRA coverage is elected; 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.

COBRA and FMLA Leave

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

- you, your spouse, or your dependent is covered by the program on the day before the leave begins (or you or your dependent becomes covered during the FMLA leave); and
- you don't return to employment at the end of the FMLA leave or you terminate employment during your leave.

COBRA coverage begins on the earlier of the following:

- when you inform the COBRA Administrator that you are definitely not returning to work; or
- the end of the leave, if you don't return to work.

COBRA and Military Leaves of Absence (USERRA)

If you take a military leave of absence that qualifies as a leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), you may continue medical coverage for up to 24 months as long as you give advance notice (with certain exceptions) of the leave to LANL Benefits Office at (877) 677-1806

or (505) 667-1806.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the portion you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the entire cost of the coverage. You can continue medical coverage for the lesser of 24 months, beginning on the date the absence begins, or the length of the leave.

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

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

Under circumstances in which COBRA continuation coverage rights also apply (see "Federal COBRA Continuation Coverage" above for information on COBRA), an election for continuation coverage will be an election to take concurrent COBRA/USERRA medical coverage.

For additional information on military leaves, such as how to request a leave and other rights and obligations, as well as their impact on Plan benefits, please contact LANL Benefits Office at (877) 667-1806 or (505) 667-1806.

COBRA and Other Leaves of Absence

For questions regarding COBRA and disability, workers' compensation, and other leaves, contact LANL Benefits Office at (877) 667-1806 or (505) 667-1806.

COBRA and Retiree Medical Coverage

If you lose health Benefit Program coverage under the Plan as an active employee, and are eligible for retiree medical coverage, you can choose COBRA instead of retiree medical coverage. If you choose COBRA, you will lose your right to elect retiree medical coverage when COBRA ends.

Benefit Program Changes During COBRA

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

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.

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.

Conversion Privileges

Some health Benefit 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 B.

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

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

Behavioral Health Benefits. There is no stand-alone conversion coverage available for behavioral health benefits. However, if you convert the medical 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.

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 material. See Appendix B.

If you do not receive the coordination of benefits procedures as a part of the Benefit Program material for health benefits, please contact the LANL Benefits Office at (877) 667-1806 or (505) 667-1806.

If you and your dependents are enrolled in a LANS health Benefit Program as well as another 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 LANS-sponsored 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 divorced or separated or are not living together, whether or not they were ever married, 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 continue to work for LANS after age 65 and are eligible for Medicare, you may continue your medical coverage under a LANS program and coordinate the program with Medicare. In general, the LANS program would be primary and pay benefits first for:

- Eligible employees age 65 and over with current employment status and spouses age 65 and over who participate in the LANS program on the basis of the employee's current employment status.
- Social Security disabled individuals who are covered by the LANS program on the basis of current employment status (their own or a family member's current employment status) and who are entitled to Medicare benefits (e.g., disabled spouses or dependents of an active employee, or Social Security disabled participants who have returned to work).
- For certain individuals who become eligible for Medicare on the basis of having end-stage renal disease (ESRD), regardless of the reason for the employer coverage, or whether they are eligible for Medicare on the basis of age or disability, for the first 30 months of Medicare entitlement due to ESRD.

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

When, under the Medicare Secondary Payor 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.

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 in writing 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 in writing terminate or partially terminate the Plan, or discontinue contributions at any time. In addition, LANS reserves the right to amend or terminate in writing covered expenses, benefit co-payments, lifetime maximums, and reserves the right to amend in writing the programs to require or increase participant contributions. LANS also reserves the right to amend in writing 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 D for information on which health and welfare Benefit Programs are insured.

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

The "make whole" doctrine does not apply and does not limit the Plan's right to recover amounts it has paid on your behalf. Furthermore, you must pay the Plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury. If any money is left over, you may keep it.

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

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

- Money from a third party that you, your guardian or other representatives receive or are entitled to receive;
- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive;

- Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid; and
- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives.

As a Plan participant, you are required to:

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

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

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

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

No Estoppel of Plan

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

Thus, if a benefit is paid to a person under the Plan or Benefit Program and it is thereafter determined by the Plan Administrator that such benefit should not have been paid (whether or not attributable to an error by such person, the Plan Administrator or any other person), then the Plan Administrator may take such action as it deems necessary or appropriate to remedy such situation, including without limitation, by deducting the amount of any such overpayment from any succeeding payments to or on behalf of such person under the Plan or Benefit Program or from any amounts due or owing to such person by LANS or under any other plan, program or arrangement benefiting the employees or former employees of LANS, 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 B 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 employee 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 Plan participant 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 nor your dependents nor your beneficiaries may assign, sell, transfer, pledge, charge, encumber or allow the attachment or alienation of any amount payable to you, your spouse, dependents, or any beneficiaries at any time under the Plan. Any attempt to so assign, sell, transfer, pledge, charge, encumber or allow the attachment or alienation of any such amount, whether presently or thereafter payable will be void. 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, LANS 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, LANS 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, vision, dental, and Health Care Reimbursement Account) for yourself, spouse, and/or your dependents if there is a loss of coverage under the Benefit Program as a result of a qualifying event. You and your dependents may have to pay for such coverage. For more details, review Section 9, "Continuation of Health Care Coverage," in this SPD, the relevant Benefit Program materials, and the COBRA notice that was mailed to your home. If you need another copy of any of these documents, please contact LANL Benefits Office at (877) 667-1806 or (505) 667-1806.

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. After exhausting your appeal rights, 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: Benefit Program Materials

Appendix C: Claim and Appeals Administration Information

Appendix D: Funding and Contract Administration Information

Appendix E: Plan Administration Information

Appendix A: Premium Contribution Arrangements

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

Benefit	Full Benefits	Mid-level Benefits	Core Benefits
Core New Mexico	Paid by LANS	Paid by LANS	Paid by LANS
All other Medical	Paid by LANS and Employee	Paid by LANS and Employee	N/A
Dental	Paid by LANS	N/A	N/A
Vision	Paid by LANS	N/A	N/A
Core Life	N/A	Paid by LANS	Paid by LANS
Basic Life	Paid by LANS	N/A	N/A
Supplemental Life	Paid by Employee	Paid by Employee	N/A
Dependent Life (Basic and Expanded)	Paid by Employee	Paid by Employee	N/A
Accidental Death and Dismemberment (AD&D)	Paid by Employee	Paid by Employee	Paid by Employee
Short-term Disability (STD)	Paid by LANS	N/A	N/A
Supplemental Disability	Paid by Employee	N/A	N/A
LANS Defined Benefit Eligible Disability Program	Paid by LANS (certain UC Transitioning Employees who properly elected TCP1 with 5 years of service at time of disability application, only)	N/A	N/A
Business Travel Accident, Global Travel, Corporate Aircraft Travel, War Risk Invalidation	Paid by LANS	Paid by LANS	Paid by LANS
Special Accident - Bomb Squad Accident Program, Field Deployment Team Accident Program	Paid by LANS (certain Employees only)	N/A	N/A
Legal	Paid by Employee	Paid by Employee	Paid by Employee
Health Care Reimbursement Account (HCRA)	Paid by Employee	Paid by Employee	Paid by Employee
Dependent Care Reimbursement Account (DCRA)	Paid by Employee	Paid by Employee	Paid by Employee
Severance	Paid by LANS	Paid by LANS	Paid by LANS

Benefit	Full Benefits	Mid-level Benefits	Core Benefits
LANS Defined Benefit Eligible Survivor Income Program	Paid by LANS (certain UC Transitioning Employees who properly elected TCP1 with 5 years of service at time of disability application, only)	N/A	N/A

Appendix B: Benefit Program Materials

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

Medical	Benefit Program Material
Blue Cross	
Core New Mexico (BlueCard) Without Medicare	http://int.lanl.gov/worklife/benefits/docs/pdfs/core_bps_06.pdf
Core New Mexico (Prudent Buyer) In California Without Medicare	http://int.lanl.gov/worklife/benefits/docs/pdfs/core_ca_bps.pdf
United HealthCare	
Definity Health – New Mexico	http://int.lanl.gov/worklife/benefits/docs/pdfs/definity_06.pdf
Options PPO New Mexico/Options PPO National	http://int.lanl.gov/worklife/benefits/docs/pdfs/ppo_spd_06.pdf
Options PPO Out-of-Area	http://int.lanl.gov/worklife/benefits/docs/pdfs/ppo_ooa_spd_06.pdf
Select EPO	http://int.lanl.gov/worklife/benefits/docs/pdfs/epo_spd_06.pdf
Behavioral Health – Substance Abuse*	
Definity Health - New Mexico (PacifiCare)	http://int.lanl.gov/worklife/benefits/docs/pdfs/pcbh_definity_bps.pdf
Options PPO New Mexico/ Options PPO National (PacifiCare)	http://int.lanl.gov/worklife/benefits/docs/pdfs/pcbh_pponm_bps_06.pdf
Options PPO Out-of-Area (PacifiCare)	http://int.lanl.gov/worklife/benefits/docs/pdfs/ppo_ooa_spd_06.pdf
Select EPO (PacifiCare)	http://int.lanl.gov/worklife/benefits/docs/pdfs/pcbh_epo_06.pdf
Dental	
Dental	http://int.lanl.gov/worklife/benefits/docs/pdfs/delta_spd_06.pdf
Vision	
Vision	http://int.lanl.gov/worklife/benefits/docs/pdfs/vsp_spd_06.pdf
Life Insurance	
Basic and Core Life	http://int.lanl.gov/worklife/benefits/docs/pdfs/life_bsp_2006.pdf
Supplemental	http://int.lanl.gov/worklife/benefits/docs/pdfs/life_bsp_2006.pdf
Basic and Expanded Dependent Life	http://int.lanl.gov/worklife/benefits/docs/pdfs/life_bsp_2006.pdf
Accidental Death & Dismemberment (AD&D)	
AD&D	http://int.lanl.gov/worklife/benefits/docs/pdfs/add_spd_06.pdf
Short-Term Disability (STD)	
Short-Term Disability	http://int.lanl.gov/worklife/benefits/docs/pdfs/stdi_bps_06.pdf
Supplemental Disability	
Supplemental Disability	http://int.lanl.gov/worklife/benefits/docs/pdfs/supdis_bps_06.pdf

**Offered as part of United HealthCare medical programs only.*

Defined Benefit Eligible Disability Program	
LANS Defined Benefit Eligible Disability Program	http://int.lanl.gov/worklife/benefits/docs/pdfs/db_disability_bps_06.pdf
Business Travel Accident (BTA)	
Business Travel Accident, Global Travel, Corporate Aircraft Travel, War Risk Invalidation	http://int.lanl.gov/worklife/benefits/docs/pdfs/bta_bps_06.pdf
Legal Plan	
Legal Plan	http://int.lanl.gov/worklife/benefits/docs/pdfs/arag_bp_06.pdf
Health Care Reimbursement Account/ Dependent Care Reimbursement Account	
LANS Health Care Reimbursement Account (HCRA)/ LANS Dependent Care Reimbursement Account (DCRA)	http://int.lanl.gov/worklife/benefits/docs/pdfs/hcra_dcra_spd_06.pdf
Defined Benefit Eligible Survivor Income Program	
LANS Defined Benefit Eligible Survivor Income Program	http://int.lanl.gov/worklife/benefits/docs/pdfs/db_bps_06pdf.pdf

Please contact the **LANL Benefits Office at (877) 667-1806 or (505) 667-1806** if you do not receive the Benefit Program material for the program in which you are enrolled.

Appendix C: Claim and Appeals Administration Information

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

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

Benefit Program	Claims Administrator
Medical	
Blue Cross of California Core New Mexico (BlueCard) Without Medicare Core New Mexico (Prudent Buyer) in California Without Medicare	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 Definity Health – New Mexico 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
Behavioral Health – Substance Abuse*	
PacifiCare Behavioral Health, Inc Definity Health - New Mexico 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
Vision	
Vision Service Plan	Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670 1-800-877-7195 www.vsp.com

*Offered as part of United HealthCare medical programs only.

Benefit Program	Claims Administrator
Basic and Core, Dependent, and Supplemental Life	
The Prudential Insurance Company of America	The Prudential Insurance Company of America Group Life Claim Division Post Office Box 8517 Philadelphia, Pennsylvania 19176 1-800-524-0542 www.prudential.com
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
Short-Term Disability (STD) & Supplemental Disability	
Liberty Life Assurance Company of Boston	Liberty Life Assurance Company of Boston Western Regional Claims Office Post Office Box 37500 Phoenix, Arizona 85069-7500 1-800-838-4461 www.libertymutual.com
LANS Defined Benefit Eligible Disability Program	
Liberty Life Assurance Company of Boston	Liberty Life Assurance Company of Boston Western Regional Claims Office Post Office Box 37500 Phoenix, Arizona 85069-7500 1-800-838-4461 www.libertymutual.com
Business Travel Accident (BTA)	
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
Special Accident	
AIG Life Insurance Company	American International Companies Accident & Health Claims Division Post Office Box 15701 Rockwood Plaza Complex Wilmington, DE 19850-5701 1-800-551-0824 1-302-661-4176 www.aig.com

Benefit Program	Claims Administrator
Legal	
ARAG®	ARAG® Post Office Box 9171 Des Moines, IA 50309-9171 1-800–247-4184 http://members.araggroup.com/lans
Dependent Care Reimbursement Account (DCRA) (not an ERISA benefit; included for convenience only)	
United HealthCare Insurance Company	United HealthCare Insurance Company Post Office Box 30555 Salt Lake City, Utah 84130 1-800-603-3816 www.myuhc.com
Health Care Reimbursement Account (HCRA)	
United HealthCare Insurance Company	United HealthCare Insurance Company Post Office Box 30555 Salt Lake City, Utah 84130 1-800-603-3816 www.myuhc.com
Severance	
Plan Administrator	Plan Administrator LANL Benefits Office P.O. Box 1663, MS P280 Los Alamos, NM 87545
LANS Defined Benefit Eligible Survivor Income Program	
Plan Administrator	Plan Administrator LANL Benefits Office P.O. Box 1663, MS P280 Los Alamos, NM 87545
COBRA Administrator	
Plan Administrator	Plan Administrator LANL Benefits Office P.O. Box 1663, MS P280 Los Alamos, NM 87545

Appendix D: 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 of California 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 Definity Health – New Mexico 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
Behavioral Health – Substance Abuse*	
Definity Health – New Mexico 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	insured
Vision	
Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670	insured

*Offered as part of United HealthCare medical programs only.

Life	
The Prudential Insurance Company of America 751 Broad Street Newark, NJ 07102-3777	insured
Accidental Death & Dismemberment (AD&D)	
AIG Life Insurance Company American Home Assurance Company Two Rincon Center 121 Spear Street San Francisco, CA 94105-1588G	insured
Short-Term Disability (STD) & Supplemental Disability	
Liberty Life Assurance Company of Boston 175 Berkeley Street Boston, MA 02117	insured
LANS Defined Benefit Eligible Disability Program	
Liberty Life Assurance Company of Boston 175 Berkeley Street Boston, MA 02117	self-funded
Business Travel Accident (BTA)	
AIG Life Insurance Company American Home Assurance Company Two Rincon Center 121 Spear Street San Francisco, CA 94105-1588 Global Travel benefits: Insurance Company of the State of Pennsylvania, a subsidiary of AIG Life Insurance Company	insured
Special Accident	
AIG Life Insurance Company American Home Assurance Company Two Rincon Center 121 Spear Street San Francisco, CA 94105-1588	insured
Legal	
ARAG® 400 Locust Street, Suite 480 Des Moines, IA 50309 800-247-4184 515-246-8710 (fax) service@ARAGgroup.com	insured

Dependent Care Reimbursement Account (DCRA) (not an ERISA benefit; included for convenience only)	
United HealthCare Insurance Company 450 Columbus Boulevard Hartford, Connecticut 06115-0450	self-funded
Health Care Reimbursement Account (HCRA)	
United HealthCare Insurance Company 450 Columbus Boulevard Hartford, Connecticut 06115-0450	self-funded
Severance	
LANS Self-administered by LANS	self-funded
LANS Defined Benefit Eligible Survivor Income Benefit	
The Prudential Insurance Company of America 751 Broad Street Newark, NJ 07102-3777	self-funded

Appendix E: Plan Administration Information

Official Plan Name	LANS Welfare Benefit Plan for Employees (See Appendix B for a listing of Benefit Programs applicable to this SPD).
Employer/Plan Sponsor	Los Alamos National Security, LLC Los Alamos Research Park 4200 West Jemez Road, Suite 200B Los Alamos, NM 87544 (505) 663-5340
Employer I.D. Number (EIN)	20-3104541
Plan Number	501
Type of Plan	The Benefit Programs are welfare benefit plans which may include medical, dental, vision, life, accidental death and dismemberment, disability, business travel accident, special accident, legal, health care reimbursement account, severance, and survivor income benefits.
Type of Administration/ Insurance Issuers	The Benefit Programs are provided under both self funded and insured arrangements. The insured programs are provided under group contracts between 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	Los Alamos National Security, LLC Benefits and Investment Committee LANL Benefits Office P.O. Box 1663, MS P280 Los Alamos, NM 87545
Claims Administrator	See Appendix C.
Agent for Service of Legal Process	Registered Agent Attention: LANS Counsel LANS, LLC 4200 West Jemez Road Suite 200B Los Alamos, NM 87544
Plan Year	Generally January 1 – December 31 (2006 Plan Year is June 1 – December 31)
Contribution Sources	LANS and participant contributions