SUMMARY PLAN DESCRIPTION

Los Alamos National Security, LLC FLEXIBLE SPENDING ACCOUNT

Effective: January 1, 2008

Group Number: 711467

UnitedHealthcare®
A UnitedHealth Group Company

FLEXIBLE SPENDING ACCOUNT PLANS

Notice To Employees

This booklet describes the Employer-sponsored Flexible Spending Account Plan ("Plan") as of January 1, 2008.

Los Alamos National Security, LLC has entered into an arrangement with United HealthCare Insurance Company, Hartford, CT ("UnitedHealthcare") under which UnitedHealthcare will process reimbursements and provide certain other administrative services to the Plan.

UnitedHealthcare does not insure the benefits described in this booklet.

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PLAN HIGHLIGHTS

Under the Plan, you can elect to establish two Flexible Spending Accounts ("FSAs"). These accounts let you make before-tax contributions from your salary, which can then be used to reimburse yourself for Eligible Expenses.

The **Health Care Spending Account ("HCRA")** is for reimbursement of Eligible Health Care Expenses (defined in the ***Health Care Spending Account*** section), including certain medical and dental expenses for you, your spouse, your dependent children, and any other dependents you can claim on your federal tax return.

The **Dependent Care Spending Account ("DCRA")** is for reimbursement of Eligible Dependent Care Expenses (defined in the ***Dependent Care Spending Account*** section), such as day care.

You can elect to participate in the HCRA, the DCRA, or both.

Each Plan year (January 1, 2008 through December 31, 2008) you can contribute to your HCRA and DCRA, and then, during the Plan year, you can receive reimbursement from the appropriate account for Eligible Expenses that are not otherwise reimbursed. Contribution levels are set forth below.

WHO IS ELIGIBLE AND HOW TO START YOUR FLEXIBLE SPENDING ACCOUNT

Who is Eligible

Regular full-time employees of the Plan Sponsor who are scheduled to work at his or her job 50% of the time or at least 20 hours per week are eligible to participate in the Plan.

When You May Enroll

You may elect to participate in the Plan during your first 31 days of employment or during any subsequent annual enrollment period. If you do not elect to participate during your first 31 days of employment, you must wait until the next annual enrollment period to elect to participate in the Plan, unless you have experienced a qualified change in status. (See the ***Changing Your Contribution Amounts*** section below.) You will need to enroll each year, even if you enrolled in the Plan the year before.

How to Enroll

You elect to participate in the Plan by completing an enrollment form. You must specify the amount of before-tax dollars you wish to contribute to the HCRA, the DCRA, or both.

To enroll, call your Benefits Representative within 31 days of the date you first become eligible to participate in the Plan. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to participate in the Plan.

Each year during annual Open Enrollment, you have the opportunity to review and change the amount of before-tax dollars you wish to contribute to the HCRA, the DCRA, or both. Any changes you make during Open Enrollment will become effective January 1 of the following year.

CONTRIBUTIONS

Each year, you must decide the amount of before-tax dollars you want to contribute to the accounts. You may contribute to the HCRA or DCRA, or both, however, amounts contributed to one account cannot be used to reimburse expenses under the other account. You should carefully estimate your Eligible Health Care and Dependent Care Expenses, collectively referred to throughout this booklet as "Eligible Expenses", for the upcoming Plan year because IRS regulations require that you forfeit any unused funds remaining in either account after the end of the Plan year.

You have until March 15 of the plan year following the year you enroll to incur an Eligible Expense. All claims for reimbursement must be submitted by June 15 of the plan year following the year you enroll, or you will forfeit all remaining funds in either account.

For the Health Care Spending Account, you may elect to contribute between $180 and $5000 a year.

For the Dependent Care Spending Account, you may elect to contribute between $180 and $5,000 or if you are married and filing separately for federal income tax purposes, you may elect to contribute up to $2,500 a year.

Contributions to the Reimbursement Accounts are deducted from your paychecks on a before-tax (tax-free) basis—before federal, state, and Social Security (FICA) taxes are taken out. Your annual election amount(s) is divided equally and deducted equally from your paychecks throughout the year.

CHANGING YOUR CONTRIBUTION AMOUNTS

IRS regulations do not permit you to stop or change the amount you contribute to a flexible spending account during the Plan year, unless you experience a Qualified Change in Status.

A. With regard to both a HCRA and a DCRA, a Qualified Change of Status may include any one of the following:

- An event that results in a change in your legal marital status, including your marriage, the death of your spouse, or your divorce, legal separation or annulment.
- An event that results in a change in the number of your dependents, including birth, adoption, placement for adoption or death of a dependent.
- An event that results in a change in the employment status of you, your spouse or dependent, including termination or commencement of employment, a strike or lockout, the commencement of or return from an unpaid leave of absence.

- An event that causes your dependent to satisfy or cease to satisfy the eligibility requirements for dependent group health coverage or coverage under the DCRA due to the attainment of age, student status or any similar circumstances, as provided under the group health plan under which you receive coverage or under the DCRA, as applicable.
- Other Qualified Changes in status, as outlined in the LANS Health & Welfare Benefit Plan for Employees

B. For individuals who participate in a HCRA, the following additional events will enable you to change your election:

- If you become entitled to Medicare or Medicaid, you may elect to revoke your HCRA coverage.
- If the FSA Plan Sponsor receives a judgment, decree or order resulting from your divorce, legal separation, annulment or change in legal custody that requires group health coverage for your dependent child then the FSA Plan Administrator may:
  - ♦ If the order requires you to provide coverage for the child under the HCRA, change your election to provide coverage for that child.
  - ♦ If the order requires your former spouse to provide coverage, permit you to cancel your child's coverage under the HCRA.

C. For individuals who participate in a DCRA, the following events, in addition to those in (A.) above will enable you to change your election:

- A change in your dependent care provider.
- If your dependent care provider significantly increases or decreases the cost of the dependent care, but only if the dependent care provider that imposes the cost change is not related to you.
- An event that results in a change in work site.
- A change in the place of residence of you, your spouse, or dependent, as allowed by IRS regulations.

The above rules are intended to be consistent with the IRS regulations under Section 125 of the Internal Revenue Code, and to the extent there is any inconsistency, those regulations shall control.

Any new election hereunder must be on account of and correspond with the change in status event. As used herein, "dependent" means a tax dependent under Section 152 of the Internal Revenue Code.

- Changes in contribution amounts made during the Plan year are generally effective as of the first of the month following the change in status, subject to LANL payroll deadlines. In any event, the commencement, change or cancellation dates represented in the the LANS Health & Welfare Benefit Plan for Employees document shall control.

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HEALTH CARE SPENDING ACCOUNT

Eligible Health Care Expenses

To be eligible for reimbursement from your HCRA, the health care expenses must be:

- Incurred for medical care, defined in Section 213(d) of the Internal Revenue Code as amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body;
- Incurred while you are participating in the Plan;
- Incurred during the Plan year.

Please note
Any reimbursement you receive through your HCRA can not be reimbursed under any other plan covering health benefits, including a spouse's or dependent's plan.

Below is a partial list of the types of health care expenses eligible for reimbursement from your HCRA. Generally, Eligible Health Care Expenses are those for which you could have claimed a tax deduction on an itemized federal income tax return (without regard to any threshold limitation) including any copayment, coinsurance or deductible amounts.

A more comprehensive list of eligible expenses are available at **myuhc.com**. Some guidance regarding what constitutes eligible medical expenses (including additional examples) is provided in IRS Publication 502 which is available from any regional IRS office, IRS website **www.irs.gov** or by phone at 1-800-TAX-FORM (1-800-829-3676). **However, there are certain expenses which are listed as deductible in IRS Publication 502, but which cannot be reimbursed by the HCRA because of IRS rules (e.g., insurance premiums)**.

Eligible Medical Expenses

- Copayments, Coinsurance and Deductible amounts;
- Routine physical exams;
- Routine lab and x-rays performed for medical reasons;
- Birth control items prescribed by your doctor;
- Childbirth classes;
- Cardiac rehabilitation classes;
- Drug abuse treatment centers;
- Sterilization unless prohibited by law;
- Other qualified 213(d) medical expenses not covered by the underlying medical plan.

Vision Expenses

- Routine eye examinations;
- Eye glasses;

- Contact lenses, including all necessary supplies and equipment.

Hearing Expenses

- Routine hearing examinations;
- Hearing aids and repairs;
- Cost and repair of special telephone equipment for the deaf.

Dental Expenses

- Copayments, Coinsurance and Deductible amounts;
- Preventive Care;
- Exams, cleanings, x-rays, root canals and bridges;
- Dentures and fillings.

Prescription Drugs

- Copayments, Coinsurance and Deductible amounts;
- Cost for allowable prescription drugs.

Over-the-Counter Medications

- Over the counter non-prescription drugs and medicines incurred for medical care (such as allergy medicines, antacids, cold medicines and pain relievers).

Ineligible Expenses

The partial list below includes examples of expenses that are not eligible for reimbursement:

- Expenses incurred for cosmetic surgery or other similar procedures, unless the procedure is necessary to improve deformities directly related to a congenital condition, a personal injury or a disfiguring disease.
- Expenses for custodial care in a nursing home.
- Insurance premiums, including Medicare Part B premiums, long term care premiums, and other payments or contributions for health coverage (such as contributions for coverage under an employer-sponsored group health plan or HMO or other health plan).
- Expenses incurred for general good health (such as vitamins and other dietary supplements, and toothpaste).
- Expenses incurred before the effective date of your account.

In addition, as with any other expense reimbursed under an employer-sponsored medical or dental plan, health expenses reimbursed through your HCRA cannot be claimed as deductions on your income tax return.

DEPENDENT CARE SPENDING ACCOUNT

Eligible Dependent Care Expenses

Eligible Dependent Care Expenses that can be reimbursed from your DCRA are expenses incurred for household and dependent care services that enable you and (if married) your spouse to be gainfully employed, which generally means working or actively looking for work.

If your spouse has no earned income, you cannot use a DCRA unless your spouse is physically or mentally incapable of caring for himself or herself, or is a full-time student for at least five months during the Plan year.

To qualify for reimbursement, Dependent Care Expenses cannot exceed your earned income or, if married, the earned income of the lesser earning spouse. Earned income (including any self-employment earnings) is generally the remaining salary after all pre-tax salary reductions have been made. If married and your spouse is physically or mentally incapable of caring for himself or herself or is a full-time student, the IRS considers your spouse to have a monthly income of $250 (as adjusted from time to time) if you have one dependent, or $500 (as adjusted from time to time) if you have two or more dependents, for each month that your spouse is incapable of caring for himself or herself or is a full-time student.

Dependent Care Expenses must be incurred for a qualified dependent. Qualified dependents are:

- A dependent under federal tax law who is a child under age 13.
- A spouse or dependent under federal tax law who is physically or mentally incapable of caring for himself or herself; provided that such spouse or dependent lives in your home for more than one-half of the year.

Eligible Dependent Care Expenses include, but are not limited to, the following expenses if not otherwise excluded:

- Expenses for care at a day care center and day care transportation that complies with all applicable state and local regulations.
- Expenses for licensed nursery school fees.
- Expenses for care provided by a housekeeper, babysitter or other person in your home who primarily cares for eligible children or an adult dependent.
- Expenses for care provided by a relative who cares for your qualified dependents, so long as that relative is over the age of 19 and is not your dependent under federal tax law.
- Expenses for care for a qualified dependent age 13 or over, including a spouse or adult dependent, who is physically or mentally incapable of caring for himself or herself. If you are claiming reimbursement for care outside your home for such dependent, the dependent must spend at least 8 hours each day in your home.

- Expenses for care at a day camp to which you send your children (under age 13) during school vacations so that you and your spouse, if you are married, can be gainfully employed or attend school full-time.

Dependent Care Tax Credit vs. Dependent Care Spending Account

Some employees may be eligible to claim a dependent care tax credit on their federal income tax return. This credit is available for the same types of expenses as the DCRA. However, the IRS requires that the dependent care tax credit be reduced, dollar for dollar, by the amount reimbursed under a Dependent Care Flexible Spending Account. In other words, you cannot use expenses reimbursed through the DCRA to claim the tax credit.

For more information about how the dependent care tax credit works, see IRS Publication No. 503. In addition, because each employee's situation is different, you may.

CONSUMER ACCOUNTS CARD

You will be provided with a Consumer Accounts Card that may be used to deduct eligible health care and dependent day care out-of-pocket expenses directly from your HCRA or DCRA. The Consumer Accounts Card allows for direct payment to qualified locations and providers and can be used at any approved location that accepts MasterCard®. The Consumer Accounts Card may not be used to purchase eligible Over The Counter expenses at retail facilities such as Walgreen's at this time. Use of the Consumer Accounts Card is voluntary.

Important
You should familiarize yourself with the specific products and services that are eligible for card use based on this Plan. Go to **myuhc.com** to learn how to get the most out of your Consumer Accounts Card.

Receiving Your Consumer Accounts Card

You will automatically receive two Consumer Accounts Cards. Read the terms and conditions found on the card insert and sign the back of your card. Los Alamos National Security, LLC has chosen to Opt Out of all information sharing for this plan not directly related to the resolution or payment of claims under the applicable Flexible Spending Account. However, you may also choose to Opt Out on an individual level by completing and returning the Privacy Statement included in your initial card mailing. You may call the customer service number listed on the back of the Consumer Accounts Card to order additional cards.

Activating Your Consumer Accounts Card

If you choose to activate the Consumer Accounts Card you will need to call the toll-free number indicated on the sticker affixed to the card and follow the voice prompts to activate. The card will be ready to use one (1) business day following activation.

~~By a~~Activating the card will not eliminate ~~you will no longer be able to use~~ the automatic reimbursement feature described below. ~~in order to avoid~~If you experience a duplicate claim payment~~s~~ please contact UnitedHealthcare at the number listed on the back of your ID Card.

If you decide not to activate the Consumer Accounts Card, simply destroy and discard both cards.

Please note
You will need to wait until your Plan's effective date before attempting to activate your card.

Qualified Locations and Providers

The Consumer Accounts Card may be used at any approved provider or merchant with a Point-of-Service (POS) bankcard terminal that accepts MasterCard®. Examples of qualified locations and providers include hospitals, physician and dental offices, vision care providers, retail pharmacy counters, and child and adult day care facilities. **You may only use your Consumer Account Card to purchase IRS approved Over The Counter Expenses through drugstore.com via myuhc.com.**

The Consumer Accounts Card can also be used at online pharmacies or for mail order prescriptions if your coverage is through UHC. For Eligible Expenses, your Consumer Accounts Card number can be entered online or on an order form, similar to using a credit card number.

Contacting a Customer Care Professional is easy.
Simply call our toll-free number at 1-866-755-2648 available 24 hours a day.
- Order Additional cards
- Report a lost or stolen card
- Get answers concerning eligible expenses or your account balances

REQUESTING A REIMBURSEMENT FROM YOUR FLEXIBLE SPENDING ACCOUNT

If you do not activate your Consumer Accounts Card or choose not to use your card, you will need to submit a reimbursement form, called a request for withdrawal, to be reimbursed from your HCRA and/or DCRA for the Eligible Expenses that have been incurred. A request for withdrawal form is available from your Employer. However, if the automatic reimbursement feature described below is turned "on" you will not have to submit a reimbursement form for certain HCRA expenses.

For reimbursement from your HCRA, you must include proof of the expenses incurred. Proof can include a bill, invoice, or an Explanation of Benefits (EOB) from any group medical/dental plan under which you are covered. An EOB will be required if the expenses are for services usually covered under group medical and dental plans, for example, charges

by surgeons, doctors and hospitals. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other group medical/dental plans.

For reimbursement from your DCRA, you must submit proof of the services rendered, such as a bill, receipt, or invoice and Social Security or Tax Identification Number of the care provider.

Only expenses which are incurred while you are a participant in the Plan may be reimbursed from a Flexible Spending Account. In addition, expenses which are incurred during one Plan year cannot be reimbursed from funds contributed to your HCRA or DCRA during another Plan year. An expense is considered incurred when services are provided, not when you are billed or when you pay for care.

You can submit a reimbursement form as often as daily. You will be reimbursed for Eligible Expenses as long as the amount requested from either account is at least $25, except for reimbursement with respect to the last month of the Plan year. Amounts below $25 will be accumulated and processed with future payments. However, if the automatic reimbursement feature described below is turned "on" you will not have to submit a reimbursement form for certain HCRA expenses.

If you have established a HCRA, your total annual contribution is available immediately. You can request reimbursement for Eligible Expenses up to your annual contribution amount as soon as such Eligible Expenses have been incurred.

If you have established a DCRA, only the amounts you have actually contributed to the account are available for reimbursement. If you request reimbursement for more than what you have in your account, you will receive only the amount in your account. As additional contributions are made to your account, outstanding reimbursements will be processed automatically.

You have until March 15 of the plan year following the year you enroll to incur an Eligible Expense. All claims for reimbursement must be submitted by June 15 of the plan year following the year you enroll, or you will forfeit all remaining funds in either account.

In accordance with IRS regulations, amounts contributed to your HCRA or DCRA during the Plan year but remaining in your account at the end of the processing period (March 15th of the following year) cannot be returned to you or used to reimburse expenses incurred in a subsequent Plan year. These amounts are forfeited and applied as directed by the Employer in accordance with the Plan.

Important
Myuhc.com includes many features such as the options to:
- View Explanation of Benefits/Health Statements
- Utilize a savings calculator for FSA
- View your FSA summary page detailing contributions and amount left in your FSA
- View your FSA Claims Summary including claim transaction details

Automatic Reimbursement

If you did not activate your Consumer Accounts Card, your employer has elected to have Eligible Expenses for medical, pharmacy and dental claims which are not covered under your UnitedHealthcare administered medical or dental plan automatically submitted to your HCRA for reimbursement. This eliminates extra paperwork and makes it more convenient for you to use your HCRA. Automatic Reimbursement is turned "on" at the start of the Plan year. ~~You can turn auto-rollover of claims "off" or back "on" by going on to **myuhc.com**.~~

If you have medical or dental coverage through another carrier, the Automatic Reimbursement feature does not apply. In addition, the Automatic Reimbursement feature does not apply if your domestic partner is covered under your employer's group health plan. An FSA withdrawal request must be submitted for any other types of expenses such as dependent care expenses and any health expenses not submitted to your health benefits carrier.

CLAIMS PROCEDURES

Questions and Appeals

If Your Claim is Denied

If a claim for benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID Consumer Accounts card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied claim, you must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason you think your claim should be paid; and
- any documentation or other written information to support your request.

If you wish to request a formal appeal of a denied claim for reimbursement, you should call the number on the back of your ID card to obtain the UnitedHealthcare address where the appeal should be sent. For Urgent Care claims that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal. UnitedHealthcare must notify you of the benefit determination within 30 days after receiving the completed appeal.

Note: Upon written request and free of charge, any covered persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor. UnitedHealthcare's decision will be final.

The table below describes the time frames in an easy to read format which you and UnitedHealthcare are required to follow.

Claim Denial and Appeals	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after receiving an extension notice*
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
▪ if the initial claim is complete, within:	**30 days**
▪ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision

Claim Denial and Appeals	
Type of Claim or Appeal	**Timing**
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

WHEN PARTICIPATION ENDS

You will cease to participate in the Plan as of the earlier of:

- The date on which the Plan terminates.
- The end of the month following the date your employment with the Company ends, subject to LANL Payroll deadlines.
- The date you cease to be an eligible employee.
- The date you fail to make a required contribution under the terms of the Plan.
- The date you retire, unless the plan is available for retired persons and you are eligible for the plan.

Health Care Reimbursement Account

You may submit a claim for reimbursement of Eligible Expenses which were incurred during the Plan year of termination, as long as those expenses were incurred prior to the date of your termination. Any such claims must be submitted on or before March 31 of the year after the Plan year of termination.

Optional Continuation Coverage Under Your Health Care Reimbursement Account (COBRA)

Los Alamos National Security, LLC offers this continuation coverage in certain cases as a result of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. See Los Alamos National Security, LLC if you have more questions about continuation of your HCRA through COBRA.

In no event will UnitedHealthcare be obligated to provide continuation coverage to a participant if Los Alamos National Security, LLC or its designated plan administrator fails to perform its responsibilities under federal law. These responsibilities include but are not limited to notifying the participant in a timely manner of the right to elect continuation coverage and notifying UnitedHealthcare in a timely manner of the participant's election of continuation coverage.

If COBRA continuation coverage is elected by the participant, such coverage will cease at the end of the Plan year in which the qualifying event occurs and coverage cannot be continued into the next Plan year. Premiums for such continuation coverage (i.e., contributions to the account) will be paid by the participant on an after-tax basis.

UnitedHealthcare is not Los Alamos National Security, LLC's designated Plan Administrator and does not assume any responsibilities of a Plan Administrator pursuant to federal law.

Dependent Care Spending Account

You may submit claims for the Eligible Expenses you have incurred during that Plan year before your termination date against what is in your DCRA when you leave employment. Any such claims must be submitted on or before March 31 of the next Plan year.

IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

This section includes information on the administration of the Plan, as well as information required of all Summary Plan Descriptions by ERISA. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Administrator

Los Alamos National Security, LLC is the Plan Sponsor and Plan Administrator of the Los Alamos National Security, LLC and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Los Alamos National Laboratory (LANL)
LANL Benefits Office
P.O. Box 1663, Mail Stop P280
Los Alamos, NM 87544
(877) 667-1806 or (505) 667-1806
e-mail: *benefits@lanl.gov*
LANL Benefits Website for Employees: *http://int.lanl.gov/worklife/benefits/* ***Claims Administrator***

UnitedHealthcare is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

United HealthCare Insurance Company
450 Columbus Boulevard
Hartford, CT 06115-0450

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Agent for Legal Process - FSA Plan

Los Alamos National Laboratory (LANL)
LANL Benefits Office
P.O. Box 1663, Mail Stop P280
Los Alamos, NM 87544

Legal process may also be served on the Plan Administrator.

Other Administrative Information

This section of your SPD contains information about how the Plan is administered as required by ERISA.

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

Plan Name:	Los Alamos National Security, LLC
Plan Number:	501
Employer ID:	94-3067788
Plan Type:	Welfare benefits plan
Plan year:	January 1, 2008 – December 31, 2008
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employee and Company
Source of Benefits:	Assets of the Company

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- receive information about Plan Benefits;
- examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents – including pertinent insurance contracts, trust agreements, collective bargaining agreements, summary annual reports, and other documents filed with the Internal Revenue Service or the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements, and copies of the latest summary annual reports, and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies; and
- receive a summary annual report of the Plan's financial activities. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.

You will be provided a certificate of creditable coverage in writing, free of charge, from Los Alamos National Security, LLC:

- when you lose coverage under the Plan;
- when you become entitled to elect COBRA;
- when your COBRA coverage ends;
- if you request a certificate of credible coverage before losing coverage; or
- if you request a certificate of credible coverage up to 24 months after losing coverage.

You may request a certificate of creditable coverage by contacting the Plan Administrator.

If you have creditable coverage from another group health plan, you may receive a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan. Without evidence of creditable coverage, Plan Benefits for the treatment of a preexisting condition may be excluded for 12 months (18 months for late enrollees) after your enrollment date in your coverage. In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under ERISA.

If your claim for a Plan Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section, *Claims Procedures*, for details.

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 summary annual report from the Plan, and do not receive them 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 for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

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.

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 if you 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 write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. Washington, DC 20210. 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 (866) 444-3272.