

LANS Health & Welfare Benefit Plan for Retirees

Summary Plan Description

Revised July 2012

IMPORTANT

This Summary Plan Description (SPD) is intended to provide a summary of the principal features of the LANS Welfare Benefit Plan for Retirees ("Plan"). Additional information about component Benefit Programs is found in the Benefit Program Materials referenced in **Appendix C**. The documents referred to in Appendix C are hereby incorporated by reference into the SPD and the Plan.

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

Nothing in the Plan and/or this SPD shall be construed as giving any participant the right to be retained in service with Los Alamos National Security, LLC ("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.

The Plan is not a "grandfathered" plan as defined by the Patient Protection And Affordable Care Act (PPACA).

For questions or to receive a paper copy of this SPD please contact the Los Alamos National Laboratory (LANL) Benefits Office at (877) 667-1806 or (505) 667-1806 or e-mail benefits@lanl.gov. SPDs are also available electronically at *LANL Benefits Website for Retirees*: <http://www.lanl.gov/worklife/benefits/retirees/>.

TABLE OF CONTENTS

1. INTRODUCTION	1
GENERAL INFORMATION	1
PLAN DETAILS.....	1
LANS BENEFIT PROGRAMS	1
KEEP YOUR RECORDS UPDATED	2
2. ELIGIBILITY REQUIREMENTS	2
RETIREE WELFARE BENEFIT ELIGIBILITY.....	2
SERVICE CREDITS FOR ELIGIBILITY FOR RETIREE HEALTH & WELFARE BENEFITS.....	3
ELIGIBLE FAMILY MEMBERS.....	3
COVERAGE FOR FAMILY MEMBERS	4
ELIGIBLE ADULTS.....	4
ELIGIBLE CHILDREN	4
INELIGIBLE PERSONS	5
QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs).....	5
NO DUPLICATE COVERAGE	6
DOCUMENTATION	6
RESCISSION OF COVERAGE	6
LOSS OF FAMILY MEMBER ELIGIBILITY	7
REHIRED RETIREES	7
MANDATED MEDICARE – YOUR RESPONSIBILITY	7
3. HOW TO ENROLL	8
RETIREE BENEFITS	8
PERIOD OF INITIAL ELIGIBILITY (PIE).....	8
<i>Other Periods of Initial Eligibility.....</i>	<i>8</i>
SUSPENDING MEDICAL COVERAGE.....	9
<i>Annual Open Enrollment</i>	<i>9</i>
WHEN COVERAGE BEGINS	10
WHEN COVERAGE ENDS.....	10
<i>Family Members of Retirees.....</i>	<i>10</i>
HIPAA CERTIFICATE OF CREDITABLE COVERAGE.....	10
4. PAYING FOR COVERAGE	10
CHANGES TO COVERAGE AND CONTRIBUTIONS	11
<i>Retiree Contributions</i>	<i>11</i>
<i>LANS Contributions</i>	<i>11</i>
<i>Imputed income</i>	<i>11</i>
5. HEALTH PROGRAM INFORMATION.....	12
HEALTH BENEFIT PROGRAM MATERIAL	12
PROVIDER NETWORKS.....	12
MATERNITY HOSPITAL STAYS (NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT).....	13
BENEFITS FOR MASTECTOMY-RELATED SERVICES (WOMEN’S HEALTH AND CANCER RIGHTS ACT)	13
NO PRE-EXISTING CONDITIONS LIMITATIONS	13
6. OTHER BENEFITS.....	13
BENEFIT PROGRAM MATERIAL.....	13
LEGAL BENEFIT PROGRAM.....	14
7. MAKING CHANGES TO YOUR PROGRAM ELECTIONS.....	14
LIFE EVENTS	14
CONSISTENCY REQUIREMENTS	15

COVERAGE AND COST EVENTS	15
<i>Coverage Events</i>	15
<i>Cost Events</i>	15
<i>Loss of Other Coverage</i>	16
<i>Acquiring new family members</i>	16
OTHER RULES ON CHANGING COVERAGE	16
<i>Medicare or Medicaid Entitlement</i>	16
<i>Judgment, Decree or Order</i>	16
<i>Lifetime Maximum</i>	17
<i>Special Note Regarding Domestic Partner Coverage</i>	17
8. BENEFIT CLAIMS AND APPEALS PROCEDURES.....	17
HEALTH PLAN ELIGIBILITY, AND ADMINISTRATIVE ERROR APPEALS PROCEDURES	17
<i>Filing an Initial Claim</i>	17
<i>Notice of Adverse Decision</i>	17
<i>Process Definitions</i>	18
<i>Appeal of Adverse Decision</i>	18
<i>Notice of Decision on Appeal</i>	18
<i>Appeal of BMT Decision</i>	18
<i>Your Right to Information</i>	18
CONVERSION PRIVILEGES	19
<i>Medical Benefits</i>	19
<i>Behavioral Health Benefits</i>	19
<i>Dental and Vision Benefits</i>	19
RIGHT TO INDIVIDUAL HEALTH COVERAGE.....	20
10. COORDINATION OF HEALTH CARE BENEFITS	20
WHEN YOU HAVE OTHER COVERAGE.....	20
COORDINATION OF BENEFITS WITH MEDICARE.....	20
11. GENERAL PLAN PROVISIONS	21
ADMINISTRATION OF PLAN.....	21
PLAN AMENDMENT AND TERMINATION	21
INSURED BENEFITS.....	22
CONTRIBUTIONS AND PREMIUMS	22
<i>LANS' Contributions</i>	22
<i>Self Funded Benefits</i>	22
<i>No Right to Assets</i>	22
ACTS OF THIRD PARTIES.....	23
NO ESTOPPEL OF PLAN.....	23
MISUSE OF PLAN.....	23
RESPONSIBILITY FOR BENEFIT PROGRAMS	23
NO GUARANTEE OF EMPLOYMENT	23
ASSIGNMENT OF BENEFITS	24
LANS USE OF FUNDS.....	24
<i>Plan Expenses</i>	24
<i>Plan's Use of Funds</i>	24
<i>Workers' Compensation</i>	24
<i>Withholding of Taxes</i>	25
12. YOUR RIGHTS AND PRIVILEGES UNDER ERISA	25
<i>Receive Information About Your Plan and Benefits</i>	25
<i>Prudent Actions by Plan Fiduciaries</i>	25
<i>Enforce Your Rights</i>	25
ASSISTANCE WITH YOUR QUESTIONS.....	26
<i>Additional Information</i>	26

APPENDIX A: PREMIUM CONTRIBUTION ARRANGEMENTS	27
APPENDIX B: SURVIVING FAMILY MEMBERS WELFARE BENEFITS.....	28
MEDICAL, DENTAL, AND LEGAL COVERAGE	28
LANS CONTRIBUTION TOWARD MEDICAL AND DENTAL PREMIUMS FOR SURVIVORS	28
APPENDIX B DEFINITIONS	30
IF COVERAGE ENDS.....	31
APPENDIX C: BENEFIT PROGRAM MATERIALS.....	32
APPENDIX D: CLAIM AND APPEALS ADMINISTRATION.....	33
APPENDIX E: FUNDING AND CONTRACT ADMINISTRATION	34
APPENDIX F: PLAN ADMINISTRATION.....	35

1. Introduction

General Information

This Summary Plan Description (“SPD”) describes the Benefit Programs (defined below) sponsored by Los Alamos National Security, LLC (“LANS”) and made available to eligible retirees of LANS through the LANS Welfare Benefit Plan for Retirees (“Plan”). For purposes of this Plan, “Eligible Retiree” means an individual who meets the requirements outlined in Section 2, “Eligibility Requirements.” Please share this SPD with your family members.

LANS maintains the Plan to provide benefits for the exclusive use of its eligible retirees and their eligible family members and beneficiaries.

When the term “family member” is used in this SPD, it generally refers to spouses (as defined under federal law), same-sex domestic partners, and children who are related to an Eligible Retiree. Please read Section 2, “Eligibility Requirements” very carefully, because each Benefit Program may define the term “family member” a “dependent” in a slightly different way. Throughout this document “same sex domestic partner” means a same sex domestic partner who meets the requirements in the LANS declaration of Domestic Partnership and for whom there is a Declaration on file with LANS on a grandfathered same sex domestic partner identified to LANS by DC as of May 31, 2006.

The Benefit Program materials referenced in [Appendix C](#), together with any updates (including any Summary of Material Modifications SMMs) and open enrollment materials are hereby incorporated by reference into this SPD and the Plan. This document, including all documents incorporated by reference, is intended to meet the SPD requirements of the Employee Retirement Income Security Act of 1974 (“ERISA”). Throughout this SPD capitalized terms have special meanings which are specified in the document the first time the term is mentioned or are defined in a location in the SPF specified where the term first appears.

Plan Details

For detailed information, please refer to:

[Appendix A](#) for Premium Contribution Arrangement information

[Appendix B](#) for eligibility information for surviving family members

[Appendix C](#) for a list of the Benefit Program materials

[Appendix D](#) and Section 8 for claim and appeals administration information

[Appendix E](#) for funding and contract administration information

[Appendix F](#) for the Customer Care Center

[Appendix G](#) for Plan administration information

LANS Benefit Programs

“Benefit Programs” means all welfare benefit programs and plans maintained by LANS for its employees, former employees, and/or their family members.

The Benefit Programs offered by LANS under the Plan at this time include:

LANS Medical Program (including prescription drug coverage)

LANS Dental Program

LANS Vision Program

The Benefit Programs offered under the Plan may change from time to time. Details and contact information for these Benefit Programs are included in Appendix C.

Keep Your Records Updated

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

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

2. Eligibility Requirements

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

Please see Appendix A for information about employee premiums required under this Plan.

Retiree Welfare Benefit Eligibility

To qualify for Plan benefits (medical, dental, legal, vision), you must be included in one of the following categories and meets all other applicable requirements set forth in this document (including any Service Credit requirements set out in this section) and in the specific benefit program documents:

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

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

Category C. A former employee of LANS who is a UC Transitioning Employee¹ who properly elected TCP1, who has 5 years of Service Credits and is eligible to receive a monthly disability benefit under the LANS Defined Benefit Eligible Disability Program; or

Category D. A former LANS employee who retires from a benefits eligible appointment at LANS on or after June 1, 2006 and who is:

- a UC Transitioning Employee¹ who properly elected TCP1 and is receiving a monthly pension from the LANS Defined Benefit Pension Plan; or
- a UC Transitioning Employee¹ who properly elected TCP2 who is receiving a monthly pension from the UCRP; or
- a Direct Transfer Employee² hired on or after June 1, 2006; or

Category E. Be a LANS employee hired on or after June 1, 2006 or a UC Transitioning Employee¹ who elected TCP2 and who took a lump sum distribution of his/her UCRP pension benefit.

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

² A Direct Transfer Employee means an employee of LANS who is transferred to LANS directly from a LANS Parent Company (excluding UC-LANL) or directly from an Affiliate of a LANS Parent Company. An Affiliate of a LANS Parent Company is any company partially or fully owned by a LANS Parent Company.

To be eligible for Plan benefits if you are in Categories B., C., D and E above, you must:

- have had continuous medical coverage under the LANS Health & Welfare Benefit Plan For Employees as of the date of your termination from LANS;
- actively enroll in the Plan within 120 days of your termination from LANS; and
- either
- be at least age 50 with at least 10 years of applicable Service Credits on the date of your termination from LANS; or
- be at least age 50 on the date of your termination from LANS, have at least 5 years of applicable Service Credits and meet the “Rule of 75”³.

You may apply for legal benefits by contacting the Legal Benefit Program provider listed in Appendix E.

Service Credits for Eligibility for Retiree Health & Welfare Benefits

Service Credits means years of service with LANS on or after June 1, 2006 and any years of service transferred to LANS from UC/LANL on June 1, 2006. Service Credits also include years of service recognized for a Direct Transfer Employee by the transferring entity as of the date of transfer to LANS. Years of service with LANS are computed by following the methodology used to calculate a “Period of Service” under the LANS Defined Benefit Pension Plan. This computation methodology will be used whether or not the employee or former employee is eligible for benefits under the LANS Defined Benefit Pension Plan. The following table shows generally how Service Credits are computed for each category above:

Category of Retiree	Service Credits for Eligibility for Retiree Health & Welfare Benefits
A	Service Credits are based on years of service with UC.
B	Service Credits are based on years of service with UC.
C	Service Credits are based on years of service with UC transferred to LANS on June 1, 2006, and years of service at LANS beginning June 1, 2006.
D.1	Service Credits are based on years of service with UC transferred to LANS on June 1, 2006, and years of service at LANS beginning June 1, 2006.
D.2	Service Credits are based on years of service with UC transferred to LANS on June 1, 2006, and years of service at LANS beginning June 1, 2006.
D.3	Service Credits are based on years of service recognized and transferred to LANS on the LANS date of hire by the LANS Parent Company or Affiliate, and years of service at LANS after the date of hire at LANS.
E.	Service Credits are based on years of service with LANS on or after June 1, 2006.

Eligible Family Members

Family members may be eligible for Plan benefits as:

a family member of a retiree receiving Plan benefits ; or

a surviving family member of certain employees, certain former employees (not retired) and certain retirees as set forth in Appendix B.

³ The Rule of 75 means your age plus Service Credits equal 75.

Coverage for Family Members

A Family member is eligible for medical, dental, vision and legal coverage if the family member meets the requirements outlined in this section and for the applicable Benefit Program.

Eligible Adults

The following are eligible adult family members 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; or

your "adult dependent relative" who, as of May 31, 2006, is on a list of Adult Dependent Relatives provided to LANS by UC.

You may have only one eligible adult family members enrolled in your LANS-sponsored retiree Benefit Programs.

Eligible Children

A Child who is described in one of the categories in the table below and meets the requirements for that category is eligible for medical, dental, vision and legal benefits.

Child	Plan	Eligibility	Must meet all applicable requirements
Natural, step, placed for adoption, adopted child, or same-sex domestic partner's child	Medical, Dental	To age 26	may not be offered coverage through their own employer
Natural, step, placed for adoption, adopted child, or same-sex domestic partner's child	Vision	To age 25	unmarried
Natural, step, placed for adoption, adopted child, or same-sex domestic partner's child	Legal, Dependent Life, AD&D	To age 23	unmarried
Legal ward	All Coverage	To age 18	<ul style="list-style-type: none"> • unmarried • living with you • supported by you (50%+) and claimed as your tax dependent

<p>Overage disabled child (except a legal ward) of employee</p>	<p>All Coverage</p>	<p>No age restriction</p>	<ul style="list-style-type: none"> • unmarried • LANS group medical benefit program before age 26 with continuous coverage and the incapacity must have begun before age 26. (Exception: A new hire at LANS on or after June 1, 2006, who is not a UC Transitioning Employee⁴ may enroll an overage disabled child without any prior continuous group medical coverage) • once eligible and enrolled, continuous coverage under a LANS group benefit program must be maintained for the overage dependent; if coverage is dropped, eligibility ends • must be approved before child reaches age of exclusion specified by each coverage or by the carrier during the Period of Initial Eligibility (PIE) for newly eligible employees
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Your disabled child age 26 or older is still considered to be your eligible child and not an adult. You may enroll your same sex domestic partner's child even if you do not enroll your same sex domestic partner

Ineligible Persons

If you elected a lump sum payment through the UCRP you are not eligible for subsidized LANS retiree welfare benefits. You may become eligible for LANS retiree benefits if you earn an additional 10 years of credited service with LANS after June 1, 2006.

If you were an employee covered by a collective bargaining agreement, except as otherwise provided in such agreement.

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.

⁴ 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.

You can get a copy of the Plan's QMCSO procedures upon request to the Plan Administrator listed in Appendix G at no cost to you. In general, only children who meet the eligibility requirements as family members – for example, by meeting the age requirements – can be covered under a QMCSO. However, a QMCSO can also apply to children who:

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

No Duplicate Coverage

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

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

If duplicate enrollment occurs, the retiree must make a definitive choice and eliminate the duplications. The Plan reserves the right to receive reimbursement for any duplicate premium payments and to collect for any Plan benefits provided due to the duplicate enrollment.

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

Documentation

To verify eligibility for your family members, LANS, and the insurance carriers and third party administrators may require documentation needed to verify the relationship, including but not limited to birth certificates, adoption records, marriage certificates, verification of domestic partnership, and tax documentation. **For additional information, refer to the applicable Benefit Program material listed in [Appendix B](#).**

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.

Rescission of Coverage

If you enroll yourself or another person in a Benefit Program and you or that other person is ineligible to participate in the Benefit Program or you fail to properly notify LANS that you or your family member is no longer eligible to participate in a Benefit Program, LANS will de-enroll the ineligible participant once LANS is aware of the ineligibility.

De-enrollment will be retroactive to the initial date of participation if the person was never eligible to participate or to the first day of the pay-period following the pay-period in which the person was no longer eligible to participate if:

- the covered person is a former spouse and you failed to notify LANS of the divorce or

- you (or the covered individual) has engaged in fraud or made an intentional misrepresentation of material facts to gain or continue participation in the Benefit Program
- The following will be considered fraud or an intentional misrepresentative of facts:
 - Enrolling a person to whom you are not married at the time you enrolled, as your spouse.
 - Enrolling a person who does not meet the requirements to be your same sex domestic partner at the time you enrolled, as your same sex domestic partner.
 - Enrolling a person as your child or other dependent who is not your child or dependent at the time you enrolled.
 - Failing to de-enroll your child from the Benefit Program within 31 days of the when he or she no longer meet the eligibility requirements.
 - Providing LANS with falsified or counterfeit documents to show eligibility
 - Failure to provide documentation to determine eligibility in a timely manner when requested by LANS

In situations other than those described above, LANS will provide you with 30 days advance written notice that you or another person enrolled as your family member will be de-enrolled and LANS will de-enroll you or such other person as of the end of the 30 days period or as soon as administratively practicable thereafter.

If LANS de-enrolls you or another person enrolled as your dependent on a retroactive basis, you will not receive reimbursement for any premiums paid for coverage, you will be responsible for employer contributions and benefits paid by the Plan for the ineligible person, and you will be subject to disciplinary action including, but not limited to, LANS de-enrolling you from coverage under the Plan and prohibiting you from enrolling in coverage for a period not to exceed one year.

Loss of Family Member Eligibility

When you or any other family member no longer meets the eligibility requirements to participate in one or more LANS-sponsored Benefit Programs, it is your responsibility to de-enroll that family member from the Benefit Program within 31 days of the change in eligibility by contacting the Customer Care Center (Aon/Hewitt) in [Appendix F](#). If you do not, you are liable for any excess LANS costs and for any Benefit Program expenses incurred by the ineligible family member. Premiums will not be refunded retroactively you did not contact Customer Care to remove the ineligible family member from coverage in a timely manner. See “Ineligible Persons” in this section for more details about eligibility requirements.

Rehired Retirees

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

Mandated Medicare – Your Responsibility

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

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

Medicare Part A and Part B:

In order to remain eligible for the Plan, LANS requires each retiree, disabled member*, and enrolled family member who is eligible, to enroll in Medicare Part A and Part B *when first eligible for any Medicare program*.** If enrolled in Medicare Part A and Part B, you cannot cancel enrollment in Part B at some future date and remain covered under the LANS Medical Program .

Those who do not comply with this requirement will be permanently terminated from coverage under the LANS Medical Program and will not be eligible to re-enroll.

Medicare Part D:

Each retiree, disabled member and enrolled family member enrolled in any **LANS Medical Program** is not permitted to enroll in any Medicare Part D plan.

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

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

3. How to Enroll

Retiree Benefits

At the time you become eligible for retiree benefits, the Customer Care Center (AON/Hewitt) will mail information on how to enroll in LANS Medical Program and LANS Dental Program benefits to the home address on file with LANS. If you choose to enroll in Legal (ARAG) or AD&D (Hartford) benefits you will need to contact ARAG and Hartford directly. If you need information on enrolling in the LANS Legal or AD&D Programs please contact the LANL Benefits Office at (877) 667-1806 or (505) 667-1806.

See Appendix D for vendor contact information.

If you do not wish to enroll in the LANS Legal or AD&D Programs, you do not have to take any action and you **will not** be automatically enrolled.

It is your responsibility to complete and submit your enrollment forms for retiree benefits under the Plan within 31 days of your date of eligibility. Eligibility begins the first day of the second month following the date of termination from LANS.

You must actively enroll within 120 days of your termination from LANS, even if you wish to suspend your active participation until a later date due to other coverage. If you do not receive the enrollment information for the LANS Medical or Dental Programs, please contact the Customer Care Center (Appendix F).

Period of Initial Eligibility (PIE)

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

A PIE starts on the "event date" and ends 31 days later. For example, a PIE starts on the day you become eligible for retiree benefits.

Other Periods of Initial Eligibility

If you are not enrolled in a LANS Benefit Program, and you have a newly eligible family member, you may be eligible to enroll yourself and your eligible family member(s) at that time.

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

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

90-Day Waiting Period for Medical Coverage - If you miss your Period of Initial Eligibility (PIE), you may enroll yourself and eligible family members in medical coverage **after** a 90 consecutive calendar day waiting period that begins the day the completed enrollment form is received by the Customer Care Center. Coverage is effective after the 90 days have elapsed.

Electing No Coverage for Medical, Dental, Vision or Legal Coverage - A retiree or surviving family member may suspend enrollment in LANS Medical, Dental, or Legal Programs for yourself and/or your eligible family members because you have other group or individual coverage.

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

Suspending Medical Coverage

To suspend coverage under LANS Medical Program, a retiree or survivor must contact the Customer Care Center.

When coverage under LANS Medical Program is suspended, it also suspends coverage for all enrolled eligible family members, LANS Medicare Part B premium reimbursement (if any), and LANS Medical Program employer contributions.

(If a retiree or survivor is enrolled in a LANS Benefit Program, that coverage can be continued for the retiree or survivor and eligible family members.)

Once LANS Medical Program coverage is suspended, the retiree has the following opportunities to re-enroll in the LANS Medical Program:

Open Enrollment. You may re-enroll in the LANS Medical Program during any future open enrollment period (usually held in November), whether or not you are covered by other medical coverage unless the other coverage is non-LANS Medicare Part D coverage. If you have non-LANS Medicare Part D coverage, you are not eligible for any LANS medical benefits. See Section 2, "Eligibility Requirements, Mandated Medicare – Your Responsibility."

Involuntary Loss of Other Coverage. You may re-enroll in the LANS Medical Program as described in Section 7, "Making Changes to Your Medical, Dental, Vision, or Legal Benefit Program Elections." You will have a new PIE during which to enroll in the LANS Medical Program. Your LANS enrollment must be submitted within 31 days of your involuntary loss of coverage.

Annual Open Enrollment

If you are a current retiree, you may enroll for coverage, change your coverage level, or waive coverage in Benefit Programs during the annual open enrollment period. Open enrollment elections are effective at the beginning of the next Plan Year, generally January 1 of the following year. If you do not change your elections during open enrollment, your coverage levels will continue from the previous year with the exception of possible retiree contribution rate changes.

When Coverage Begins

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

When Coverage Ends

Retiree coverage generally ends on the earlier of:

- the last day of the month in which you suspend your benefit
- the last day of the month in which you fail to make a required contribution,
- the last day of the month in which you become ineligible for coverage,
- the date the Plan or Benefit Program terminates; or
- as further described in the Benefit Program material.

Family Members of Retirees

Coverage for family members generally ends on the earlier of:

- the last day of the month in which you fail to make a required contribution,
- the last day of the month in which your family members ceases to be eligible for coverage;
- the day retiree coverage ends;
- the date the Plan or Benefit Program terminates; or
- as further described in the Benefit Program material.

HIPAA Certificate of Creditable Coverage

When you or your family member's coverage under the LANS Medical Program 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 for the time you were covered by the LANS Medical Program against the new program's pre-existing condition limit. You may request an additional certificate from the Benefit Program listed in [Appendix D](#) at any time while covered and within 24 months after coverage ends.

4. Paying for Coverage

You and LANS share the cost of coverage under certain Benefit Programs, as described in [Appendix A](#). LANS will inform you when you enroll of your share of the cost of coverage for the relevant time period. Your portion of the cost varies according to your eligibility status, benefits and coverage levels (i.e., single, family, etc.). For more information, refer to [Appendix A](#).

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

Changes to Coverage and Contributions

Premiums are paid in advance by direct payment to the Customer Care Center in [Appendix F](#) for coverage under the Medical and Dental Programs and by direct payment to the LANS Legal Vision and AD&D Programs listed in [Appendix E](#).

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

Refer to the LANS Legal and AD&D Program documents for information about rate changes.

Retiree Contributions

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

LANS Contributions

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

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 retiree who enrolled the person. These "non-qualified" dependents may include:

- same-sex and grandfathered opposite domestic partners
- grandfathered adult dependent relatives

Federal Tax Rules For Tax-Favored Health Benefits

Family Members who are otherwise eligible for coverage under a medical and dental Benefit Program under this Plan also must satisfy the following criteria in order to be considered a "dependent" under the Internal Revenue Code and to receive tax-favored health benefits:

- "Qualifying Children". Qualifying Children are your children by birth, adoption, stepchildren, or foster children who:
 - are under age 19, or under age 26 in the case of a full-time student, on the last day of the calendar year; and
 - do not provide over one-half of their own support; and
 - have the same principal place of residence as you for more than six months of the year (temporary absences, such as for school, are treated as time at the same principal place of residence).
- "Qualifying Relatives". Qualifying Relatives include:
 - Your children (by birth, adoption, stepchildren or foster children) of any age who receive over half of their support from you and who do not meet the above "qualifying child" requirements with respect to any other person.
 - Individuals who share your residence as a member of your household, who receive over half of their support from you, and who do not meet the above "qualifying child" requirements with respect to any other person.

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

Please contact the LANL Benefits Office if you have questions concerning same sex domestic, domestic partner, dependent child or other dependent status issue.

5. Health Program Information

The Plan includes “health” Benefit Programs to include the Medical, Dental, and Vision Plans (“Health Benefit Programs”).

Health Benefit Program Material

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

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

You may also obtain a copy of the Benefit Program material for the Health Benefit Programs in which you are enrolled by contacting the program directly at the address or phone number listed in [Appendix E](#).

Provider Networks

If you are enrolled in a Health Benefit 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 Benefit Program, please contact the Health Benefit Program at the address, phone number, or Web site listed in [Appendix E](#).

Refer to the Benefit Program material in Appendix C for your Health Benefit 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 Benefit 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 Benefit 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 family members:

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

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

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

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

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

No Pre-existing Conditions Limitations

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

6. Other Benefits

Benefit Program Material

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

- eligibility to receive services;
- exclusions, limitations, and terms for obtaining coverage;
- cost sharing;
- annual and lifetime maximums and other caps or limits;

- circumstances under which services may be denied, reduced, or forfeited;
- procedures to be followed in obtaining services
- procedures available for the review of denied claims.

You may also obtain a copy of the Benefit Program material for the program in which you are enrolled by contacting the program directly at the address or phone number listed in Appendix E.

Legal Benefit Program

The LANS Legal Benefit Program (through ARAG) provides basic legal services for eligible retired employees and their eligible family members.

Employees who terminate employment and retire with LANS have the option to enroll or continue legal coverage. Former employees must contact ARAG® within 31 days of retirement to request an enrollment form, coverage information, rates and details on how to enroll. Retirees can make changes or enroll during each available Open Enrollment period. See [Appendix E](#) for ARAG® contact information.

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

7. Making Changes to Your Program Elections

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 life events occur, as further explained below.

You must contact the Customer Care Center in [Appendix F](#) within 31 days of the event to request this change. The 31 day PIE begins on the date the life event occurs and ends at the end of business on the 31st day. Should the 31st day fall on a weekend or a Holiday the PIE will be extended till the end of the next business day. Otherwise, your next opportunity to enroll new family members or make other Benefit Program changes is generally the next annual open enrollment period or the date you have another qualified event which would permit you to make a mid-year election change, 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 domestic partner.
- **Number of family members.** An event that changes your number of family members, including birth, death, adoption, and placement for adoption.
- **Employment Status.** An event that changes your, your spouse's or another family member's employment status that results in gaining or losing eligibility for coverage. Examples include:
 - Beginning or terminating employment
 - reduction in work hours

- **Family member status.** An event that causes your family member to become eligible or ineligible for coverage because of age, or other circumstances.

Detailed information about Life Events and PIEs may be obtained from the Customer Care Center (Appendix F).

Consistency Requirements

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

- **Effect on eligibility.** The Life Event must affect eligibility for coverage under the Plan or under a plan sponsored by the employer of your spouse or other dependent. For this purpose, eligibility for coverage is affected if you become eligible (or ineligible) for coverage or if the Life Event results in an increase or decrease in the number of your dependents who may benefit from coverage under the Plan.
- **Corresponding election change.** The election change must correspond with the Life Event. For example, if your dependent loses eligibility for coverage under the terms of a health program due to age, you may cancel health coverage only for that dependent.

You must contact the Customer Service Center within 31 days of the event. Otherwise, your next opportunity to make changes will be the next open enrollment period or when another event occurs which would permit you to make a mid-year election change, whichever occurs first.

Coverage and Cost Events

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

Coverage Events

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

Here are some examples:

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

Cost Events

If your cost for health program coverage increases or decreases significantly during the Plan year, you may make a corresponding election change.

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.

LANS will determine whether a change in cost is significant.

Loss of Other Coverage

This rule applies if you meet the following conditions:

- You (or your family member) were covered under other health coverage (for example, under another employer's medical plan) when LANS coverage was previously offered to you; and
- You (or your family member) lose other coverage because:
- Another employer's contributions to other coverage stop, or
- You or your family members are no longer eligible under that plan.

If you or your family member loses other health coverage due to these conditions, you may enroll yourself and your eligible family member in the LANS health plan within 31 days of the loss of coverage.

Acquiring new family members

When you acquire a newly eligible spouse or child (through marriage, birth, adoption, or placement for adoption), you may enroll yourself, your spouse, and eligible children in the LANS Health Plan within 31 days of the date you acquire the new family member.

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

Other Rules on Changing Coverage

Medicare or Medicaid Entitlement

You are required to change an election for medical coverage mid-year if you, your spouse, or family member becomes entitled to Medicare or Medicaid coverage. However, you are limited to changing your coverage only for the person who becomes entitled to Medicare or Medicaid, or for the person who loses eligibility for Medicare or Medicaid.

Judgment, Decree or Order

You may revoke an election for health coverage mid-year and make a new election if a judgment, decree, or order requires health coverage for your eligible child. The order must have resulted from a divorce, legal separation, annulment, or change in legal custody, and must meet the requirements of a qualified medical child support order (QMCSO).

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

Lifetime Maximum

A retiree (or an eligible family member) who reaches a lifetime maximum on all benefits under a non-LANS medical benefit program may be provided an opportunity to enroll in a LANS Medical Program. Contact the Customer Care Center (Appendix F).

Special Note Regarding Domestic Partner Coverage

The events qualifying you to make a mid-year election change described in this section also apply to events related to a family member 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 an event occurs which would allow a mid-year change in election. 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 "dependent." as defined in the Internal Revenue Code.

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 for more information on who qualifies as a federal tax dependent See Section 4, "Paying for Coverage."

8. Benefit Claims and Appeals Procedures

The claims procedures outlined below are representative of the actual claims procedures followed by the Claims Administrators of the Benefit Programs that are subject to ERISA and offered under the Plan

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 D](#) for a list Claims Administrators.

A claim for benefits (including eligibility to participate) 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 to you upon request (active states "automatically") and without charge by the claims administrators listed in [Appendix D](#). 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 Plan Eligibility, and Administrative Error 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 D](#) for details on filing claims.

Notice of Adverse Decision

If your claim is denied or reduced, you will be provided with a notice of adverse decision within the timeframes specified in the applicable Benefit Program material listed in [Appendix C](#)

Process 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](#).

Appeal of Adverse Decision

If you disagree with the decision on your claim including for a request or application to participate in the Plan, you (or your authorized representative) may file a written appeal with the LANS Benefit Management Team (BMT) within 30 days after your receipt of the notice of adverse decision by the Customer Care Center. 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).

Notice of Decision on Appeal

After your appeal is reviewed by BMT, you will receive an acknowledgement within 15 days of receipt of your appeal. You will receive a notice of the appeal determination from the BMT within 30 days. An extension of an additional 30 may occur if necessary to properly adjudicate the appeal. The timeframes for providing acknowledgement of receipt of an appeal and the notice of decision on an appeal generally start when a written appeal is received by the BMT. Notice of decision on appeal may be provided in writing through in-hand, mail, or electronic delivery. Note, "days" means calendar (not business) days.

Appeal of BMT Decision

If you disagree with the BMT decision on your appeal, you may file a formal ERISA appeal in writing to the Benefits Appeals Committee (BAC) within 180 days of receipt of the BMT 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 appeal to the BAC should be addressed to:

Benefits Appeals Committee

c/o Plan Administrator - LANS Health & Welfare Plan For Retirees

PO Box 1663, MS P280

Los Alamos, NM 87545

You will receive notice of the BAC appeal determination within 60 days of the receipt of the appeal by the Plan Administrator.

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. 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.

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.

Conversion Privileges

Some health programs offer conversion from group coverage to individual coverage when coverage ends.

Medical Benefits

When medical coverage ends for you or any eligible family member covered by a LANS-sponsored insured medical program you may be able to apply for an individual medical policy from that program.

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

For additional information on your conversion rights, you should check with your medical benefit provider, or refer to the appropriate Benefit Program material listed in [Appendix C](#).

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

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

Behavioral Health Benefits

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

Dental and Vision Benefits

There is no conversion coverage available for dental and vision benefits.

Right to Individual Health Coverage

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

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan;
- Your most recent coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for 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 Benefit Programs.

The coordination of benefits rules applicable to you will be those of the Benefit Program in which you are enrolled and will be furnished automatically to you without charge as a part of the applicable Benefit Program Summary. See [Appendix C](#).

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

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

Here’s how it works in general:

When the 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 a covered family member are covered under another health program, a program without a coordination of benefits provision is considered primary.

Coordination of Benefits with Medicare

If you are eligible for Medicare, you must enroll in Medicare Part A and B to continue your medical coverage under a LANS program. Medicare will then be primary and pay benefits first for:

- Eligible retirees age 65 and over and spouses age 65 and over who participate in the Plan on the basis of the retiree’s former employment status with UC or LANS.
- Social Security disabled individuals who are covered by the Plan on the basis of retiree’s former employment status with UC or LANS and who are entitled to Medicare benefits (e.g., disabled

spouses or dependents of an active employee, or Social Security disabled participants who have returned to work).

- For certain individuals who become eligible for Medicare on the basis of having end-stage renal disease (ESRD), regardless of the reason for the employer coverage, or whether they are eligible for Medicare on the basis of age or disability, after the first 30 months of Medicare entitlement due to ESRD.

When, under the Medicare Secondary Payer rules Medicare is the primary payer, benefits payable under the LANS Medical Program will be reduced by any amounts that would be paid by Medicare Part A or Part B. 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 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 LANS 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.

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

11. General Plan Provisions

Administration of Plan

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

In the event of a mistake as to the eligibility of the participation of an employee, the allocation made to your account, or the amount of benefits paid or to be paid to you or another person, the to you or another person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under the applicable law, cause to be allocated or withheld or accelerated, or otherwise make an adjustment of, such amounts as it will in its judgment accord to you or other person the benefits to which you or such other person is properly entitled under the Plan. Such action by the Plan administrator may include withholding of any amounts due to the Plan or LANS from compensation paid by LANS

Plan Amendment and Termination

LANS or its authorized delegate reserves the right in its sole discretion to amend in writing the Plan, or any Benefit Program, in whole or in part, and/or to completely discontinue the Plan or any Benefit Program at any time. LANS' decision to amend or terminate is not a fiduciary decision. It is a business decision that can be made solely in LANS' interest.

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

Insured Benefits

Certain benefits under this Plan are fully insured. See [Appendix E](#) for information on which health Benefit Programs are insured.

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

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

- Determining eligibility for and the amount of any benefits payable under the applicable Benefit Program.
- Prescribing claims and appeal procedures to be followed and the claims and appeal forms to be used by plan participants pursuant to the applicable program.
- The insurance company also has the authority to require plan participants to furnish it with such information as it determines necessary for the proper administration of the applicable program.

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

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

Contributions and Premiums

LANS' Contributions

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

Self Funded Benefits

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

No Right to Assets

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

Acts of Third Parties

When you or your covered dependent (“you”) are injured or become ill because of the actions or inactions of a third party, the Claims Administrator listed in Appendix C may cover your eligible health care (medical, prescription drug, dental and vision) expenses. However, to receive coverage, you must notify the Claims Administrator listed in [Appendix C](#) that your illness or injury was caused by a third party, and you must follow any special Claims Administrator rules.

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.

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

Misuse of Plan

LANS reserves the right to permanently 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, enrolling ineligible dependents in the Plan, allowing others to use Plan identification cards, and threats or abusive behavior towards Plan providers or representatives.

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

Responsibility for Benefit Programs

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

No Guarantee of Employment

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

Assignment of Benefits

Except as otherwise may be required under a qualified medical child support order (QMCSO) which assigns benefits to a child who has been designated as an alternate recipient in accordance with the Plan's QMCSO procedures; by applicable law; or as otherwise specifically provided in the Plan or Benefit Program material; neither you, your dependents nor your beneficiaries may assign, sell, transfer, pledge, charge, encumber or allow the attachment or alienation of any amount payable to you, your spouse, dependents, or any beneficiaries at any time under the Plan. Any attempt to assign, sell, transfer, pledge, charge, encumber or allow the attachment or alienation of any such amount, whether presently or thereafter payable will be void. If you, your spouse, dependent, or beneficiary attempt to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber any amount payable under the Plan, or any part thereof, or if a person's bankruptcy or other event would cause amounts payable under the Plan to be subject to the person's debts or liabilities, then the Plan Administrator may direct that such amount be withheld and that the same or any part thereof be paid or applied to or for the benefit of you, your spouse (as defined under federal law) or your dependents, or any of them in such manner and proportion as the Plan Administrator may deem proper. Such payment shall constitute a complete discharge of the liability of the Benefit Program and the Plan.

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

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

LANS Use of Funds

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

Plan Expenses

Plan administrative costs are paid in part by the use of forfeitures, if any. The rest of the cost of administering the Plan is paid entirely by LANS.

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.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

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

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

- Plan fiduciaries misuse the Plan's money, or
- You are discriminated against for asserting your rights.

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

Assistance with Your Questions

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

Additional Information

Additional pertinent information is attached as follows:

[Appendix A: Premium Contribution Arrangements](#)

[Appendix B: Surviving Family Members Eligibility](#)

[Appendix C: Benefit Program Materials](#)

[Appendix D: Claim and Appeals Administration Information](#)

[Appendix E: Funding and Contract Administration Information](#)

[Appendix F: Customer Care Center](#)

[Appendix G: Plan Administration Information](#)

Appendix A: Premium Contribution Arrangements

Total Medical and Dental premium costs will be determined annually by LANS. Retirees will be responsible for any part of the premium cost not paid for by LANS as described herein. **Retirees pay the entire premium for Legal, AD&D or Vision coverage should they choose such coverage.**

ELIGIBILITY CATEGORIES A-D (See Section 2 for Eligibility Rules)	LANS CONTRIBUTIONS
Service Credits⁵ for LANS Contributions (if any)	Medical and Dental Benefits
<p>A. Be a former employee of the University of California (UC) at Los Alamos National Laboratory (LANL) (or current or surviving family member of such former UC-LANL employee) who is receiving or is eligible to receive retiree welfare benefits from UC on May 31, 2006.</p> <p>Service Credits are based on years of service with UC.</p>	<p>A-D.</p> <p style="text-align: center;">Non-Medicare Eligible Retirees</p> <p>LANS contribution is determined by applying a service-based factor (Credits⁵) to LANS contribution to annual premiums, as follows:</p> <ul style="list-style-type: none"> ▪ 0-9 years of Service Credit - 0% LANS contribution unless you have at least 5 years of service and qualify under the Rule of 75. ▪ 10 years of Service Credit (or at least 5 years of service and meet the Rule of 75) - 50% LANS contribution. ▪ 11-20 - 50% LANS contribution, plus a 5% additional increment for each full year of Service Credit⁴ above 10, up to 100%. ▪ 20+ years of Service Credit – 100% of LANS contribution. <p style="text-align: center;">Medicare-Eligible Retirees</p> <p>If the participant is enrolled in Medicare Parts A&B the Plan will reimburse the retiree's Medicare Part B premium up to a maximum of \$96.40/month. Medicare Part B Reimbursement is not available for Access Only participants</p> <p style="text-align: center;">Special Rules</p> <ul style="list-style-type: none"> ▪ UC Transitioning Employees¹ who properly elected TCP1 or TCP2 upon transfer to LANS, and who were hired in a career position with UC before January 1, 1990, and who apply for LANS welfare benefits within 120 days of termination from LANS receive 100% of the LANS maximum contribution. The Rule of 75³ does not apply. ▪ Retirees who, immediately before retirement, were receiving a monthly disability benefit under the LANS Defined Benefit Eligible Disability Program continue with a 50% LANS contribution even if they have less than 10 years of service. Upon retirement, the Service Credits earned while on disability status count toward determining the percentage of the LANS contribution toward medical and dental coverage.
<p>B. Be a former employee of UC at LANL who terminated from UC before June 1, 2006, and who, within 120 days of termination from UC elected to receive a monthly pension from the University of California Retirement Plan (UCRP).</p> <p>Service Credits are based on years of service with UC.</p>	
<p>C. Be a former employee of LANS who is a UC Transitioning Employee¹ who properly elected TCP1, and who is vested with 5 years of Service Credits⁴ and is eligible to receive a monthly disability benefit under the LANS Defined Benefit Eligible Disability Program and who applies for welfare benefits within 120 days of termination from LANS.</p> <p>Service Credits are based on years of service with UC transferred to LANS on June 1, 2006, and years of service at LANS beginning June 1, 2006. The Rule of 75 does not apply.</p>	
<p>D. Be a former LANS employee who retires from a benefits eligible appointment at LANS on or after June 1, 2006 and who applies for LANS welfare benefits within 120 days of termination from LANS, <i>and who is</i></p>	
<p>1. a UC Transitioning Employee⁶ who properly elected TCP1 and is receiving a monthly pension from the LANS Defined Benefit Pension Plan;</p> <p>Service Credits are based on years of service with UC transferred to LANS on June 1, 2006, and years of service at LANS beginning June 1, 2006, or</p>	
<p>2. a UC Transitioning Employee⁷ who properly elected TCP2 who is receiving a monthly pension from the UCRP;</p> <p>Service Credits are based on years of service with UC frozen upon transfer to LANS on June 1, 2006. or</p>	
<p>3. a Direct Transfer Employee hired on or after June 1, 2006; <i>with at least 10 years of Service Credits⁴ for work performed on Department of Energy (DOE) Management and Operating, Environmental Management and other DOE Prime Contracts (including predecessor contractors.) as recognized by the transferring entity. These Service Credits are frozen upon transfer to LANS. or,</i></p>	
<p>E. a LANS employee hired on or after June 1, 2006, a UC Transitioning Employee who elected TCP2 and who takes a lump sum distribution of his/her UCRP pension benefit, or a Direct Transfer Employee⁷ hired on or after June 1, 2006 who has less than 10 years of recognized Service Credits⁴ for work performed on Department of Energy (DOE) Management and Operating, Environmental Management and other DOE Prime Contracts (including predecessor contractors) upon transfer to LANS.</p>	<p>E. No LANS contribution. Access only.</p>

⁵ Credits means years of service calculated by and transferred to LANS from any LANS Parent Company or service with LANS on or after June 1, 2006, years of service calculated by LANS generally based on the methodology used to calculate Credited Service under the LANS Defined Benefit Pension Plan (whether or not the employee is eligible for the LANS Defined Benefit Pension Plan).

⁶ 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.

⁷ A Direct Transfer Employee means an employee of LANS who was transferred to LANS directly from a LANS Parent Company (excluding UC-LANL), or directly from an Affiliate of a LANS Parent Company. An Affiliate of a LANS Parent Company is any company partially or fully owned by a LANS Parent Company. ³ The Rule of 75 means your age plus Service Credits equal 75. ⁴ Service

Appendix B: Surviving Family Members Welfare Benefits

Medical, Dental, and Legal Coverage

To be eligible for medical, dental and/or legal survivor benefits under this Plan, the surviving family member must have been enrolled in the Medical, Dental and/or Legal Benefit Program under this Plan on the date of death of the deceased retiree (“Deceased.”

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

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

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

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

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

LANS Contribution toward Medical and Dental Premiums for Survivors

For surviving family members eligible for continued medical and dental coverage, the level of LANS contribution is based on the Service Credits³ of the Deceased as earned under the rules set forth in Section 2 and Appendix A of this SPD. The percentage corresponds to the Deceased’s years of Service Credits³ as shown below.*

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

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

A Retiree from the University of California (UC) at Los Alamos National Laboratory (LANL) whose membership in the UCRP began before January 1, 1990, without a break in service from the UCRP of more than 120 days;

A LANS employee, disabled former employee, or retiree who is a UC Transitioning Employee¹ who properly elected **TCP1 who** dies at age 50 or more with at least 5 years of Service Credits³ and whose membership in the UCRP began before January 1, 1990, without a break in service from either the UCRP or the LANS Defined Benefit Pension Plan of more than 120 days.

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

LANS SURVIVOR WELFARE BENEFIT ELIGIBILITY CHART

LANS CATEGORIES	SURVIVING FAMILY MEMBERS WHO MAY BE ELIGIBLE FOR WELFARE BENEFITS See Footnotes to Appendix B, below, for additional eligibility criteria.
Deceased Employee	
TCP1	
A current LANS employee who is a UC Transitioning Employee ⁸ who properly elected TCP1 who at any age with at least 2 but less than 5 years of Service Credits ⁹ and upon whose death the employee's family member(s) are eligible for the LANS Defined Benefit Survivor Income Benefit Program.	<ul style="list-style-type: none"> ▪ Eligible Spouse⁴ ▪ Eligible Domestic Partner⁴ ▪ Eligible Child⁴ ▪ Eligible Dependent Parent⁴
A current LANS employee who is a UC Transitioning Employee who properly elected TCP1 who dies at age 50 or more with at least 5 years of Service Credits and upon whose death the employee's family members are eligible for the LANS Defined Benefit Survivor Income Benefit Program.	<ul style="list-style-type: none"> ▪ Surviving Spouse⁴ ▪ Surviving Domestic Partner⁴
TCP2	
None	▪
Deceased Former Employee	
TCP1	
A former LANS employee who is a UC Transitioning Employee who properly elected TCP1 who dies within 120 days of termination from LANS at age 50 or more with at least 5 years of Service Credits and whose surviving family members have had continuous coverage under LANS welfare benefits from the date of termination to the date of death.	<ul style="list-style-type: none"> ▪ Surviving Spouse⁴ ▪ Surviving Domestic Partner⁴
A former LANS employee who is a UC Transitioning Employee who properly elected TCP1, who dies before age 50 with at least 5 years of Service Credits ³ and is eligible to receive a monthly disability benefit under the LANS Defined Benefit Eligible Disability Program and who applied for LANS welfare benefits within 120 days of termination from LANS and whose surviving family members have had continuous coverage under the LANS welfare benefits from the date of termination to the date of death and upon whose death the Employee's family members are eligible for the LANS Defined Benefit Survivor Income Benefit Program.	<ul style="list-style-type: none"> ▪ Eligible Spouse⁴ ▪ Eligible Domestic Partner⁴ ▪ Eligible Child⁴ ▪ Eligible Dependent Parent⁴
A former LANS employee who is a UC Transitioning Employee who properly elected TCP1, and who dies at age 50 or more with at least 5 years of Service Credits and is eligible to receive a monthly disability benefit under the LANS Defined Benefit Eligible Disability Program and who applied for LANS welfare benefits within 120 days of termination from LANS and whose surviving family members have had continuous coverage under the LANS welfare benefits from the date of termination to the date of death and upon whose death the Employee's family members are eligible for the LANS Defined Benefit Survivor Income Benefit Program.	<ul style="list-style-type: none"> ▪ Surviving Spouse⁴ ▪ Surviving Domestic Partner⁴
Deceased Retiree	
A former employee of the University of California (UC) at Los Alamos National Laboratory (LANL) who terminated from UC before June 1, 2006, upon whose death the spouse or domestic partner is eligible for a monthly survivor benefit from a pension plan due to service with LANL.	Surviving Spouse⁴ Surviving Domestic Partner⁴
A former LANS employee who terminated from a benefits eligible appointment at LANS on or after June 1, 2006, and who applies for LANS welfare benefits within 120 days of termination from LANS, <i>and who is:</i>	----

⁸ 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.

⁹ Service Credits means years of service recognized by and transferred to LANS from any LANS Parent Company and/or for service with LANS on or after June 1, 2006. Years of service is calculated by LANS generally based on the methodology used to calculate Credited Service under the LANS Defined Benefit Pension Plan (whether or not the employee is eligible for benefits under the LANS Defined Benefit Pension Plan).

A UC Transitioning Employee who properly elected TCP1, who is receiving a monthly pension from the LANS Defined Benefit Pension Plan and who, upon retirement properly elected a monthly pension with his or her spouse or domestic partner, as the case may be, designated as the Contingent Annuitant; <i>or</i>	<ul style="list-style-type: none"> ▪ Surviving Spouse⁴ ▪ Surviving Domestic Partner⁴
A UC Transitioning Employee who properly elected TCP2 who is receiving a monthly pension from the UCRP and who, upon retirement properly elected a monthly pension and upon whose death the Retiree's surviving family members are eligible for a survivor income under the UCRP; <i>or</i>	<ul style="list-style-type: none"> ▪ Surviving Spouse⁴ ▪ Surviving Domestic Partner⁴

Appendix B Definitions

Deceased	Deceased means, for purposes of this Appendix B, the Deceased Employee, Deceased Former Employee or the Deceased Retiree of UC or LANS, as applicable, as set forth in the <i>LANS Survivor Welfare Benefit Eligibility Chart</i> above, upon whose death certain eligible family members may be eligible for welfare benefits under this Plan.
Deceased Disabled	A participant in the LANS Defined Benefit Disability Benefit Program or a participant in the UCRP receiving disability benefits.
Disability	To determine eligibility as a disabled spouse, domestic partner, or child, disability is defined as a medically determinable physical or mental impairment which prevents the individual from engaging in "substantial gainful activity" on the basis of qualified medical opinion. "Substantial gainful activity" means any type of gainful activity commensurate with age, education skills or general background, which could reasonably be expected to result in earnings in excess of the Social Security Administration's annually published dollar amount used to determine substantial gainful activity (\$860 per month in 2006). Eligibility is determined by the Plan Administrator, and the spouse, domestic partner, or child must cooperate with all requests for information, including medical information. The disability must be expected to continue for an extended and uncertain period of time. For a disabled spouse or domestic partner, the disability must exist at the time of the Deceased's death. For a disabled child, the disability must have arisen while the child was otherwise eligible, i.e., under age 18, or under 22 and attending an educational institution on a full-time basis.
Eligible Child	The natural or adopted child or stepchild of a Deceased or the natural or adopted child of the Deceased's domestic partner. The child must have received at least 50 percent support from the Deceased for the one year period ending on: a) in the case of a Deceased Employee, the Deceased's date of death; b) in the case of a Deceased Disabled, the Deceased's disability date; or c) in the case of a Deceased Retiree, the Deceased's retirement date. On the date of the Deceased's death, the child must be: <ul style="list-style-type: none"> ▪ under age 18, ▪ under age 22 and attending an educational institution full time, or ▪ disabled (see "Disability" above); the disability must have occurred while the child was eligible based on age, as listed above. The one-year support requirement does not apply to the Deceased's natural child born within 10 months after the Deceased's death or to the Deceased's natural child born less than one year before the Deceased's death. A stepchild or domestic partner's child must have been living with or in the care of the Deceased just before the Deceased's death.
Eligible Dependent Parent	The natural or adoptive mother or father of the Deceased who received at least 50 percent support from the Deceased for the one year period ending: a) in the case of a Deceased Employee, the Deceased's date of death; b) in the case of a Deceased Disabled, the Deceased's disability date; or c) in the case of a Deceased Retiree, the Deceased's retirement date.
Eligible Domestic Partner	The domestic partner of the Deceased established pursuant to the <i>LANS Declaration of Domestic Partnership</i> . The partnership must have been established for the one year period ending on: a) in the case of a Deceased Employee, the Deceased's date of death; b) in the case of a Deceased Disabled, the Deceased's disability date; or c) in the case of a Deceased Retiree, the Deceased's retirement date, and the partner must: <ul style="list-style-type: none"> ▪ be responsible for the care of an Eligible Child; ▪ be Disabled (see above); or ▪ have reached age 60. If the domestic partner is responsible for the care of an Eligible Child who is the Deceased's natural child, the one-year domestic partnership requirement is waived.
	If the Deceased was an employee or a disabled former employee eligible to retire (age 50 or more with at least 5 years of Service Credits ³) or a retiree, the domestic partner may be eligible to receive benefits as a Surviving Domestic Partner; see below.

Eligible Spouse	<p>The widow or widower of a Deceased. The date of the marriage must have been at least one year before: a) in the case of a Deceased Employee, the Deceased's date of death; b) in the case of a Deceased Disabled, the Deceased's disability date; or c) in the case of a Deceased Retiree, the Deceased's retirement date, and the spouse must:</p> <ul style="list-style-type: none"> ▪ be responsible for the care for an Eligible Child; ▪ be disabled (see above); or ▪ have reached age 60. (The qualifying age is 50 for a widow if (a) the spouse and Deceased were married before October 19, 1973, and (b) the Deceased had entered UCRP by that date.) <p>If the spouse is responsible for the care of an eligible child who is the Deceased's natural child, the one-year marriage requirement is waived.</p> <p>If the deceased was an employee or a disabled former employee eligible to retire (age 50 or more with at least 5 years of Service Credits³) or a retiree, the widow or widower may be eligible to receive benefits as a Surviving Spouse; see below.</p>
Eligible Survivor	<p>See "Eligible Spouse," "Eligible Domestic Partner," "Eligible Child," or "Eligible Dependent Parent."</p>
Surviving Domestic Partner	<p>The domestic partner of a Deceased established pursuant to the <i>LANS Declaration of Domestic Partnership</i>. The Surviving Domestic Partner is eligible to receive the survivor benefits without qualifying as an Eligible Domestic Partner under the following conditions:</p> <ul style="list-style-type: none"> ▪ Deceased Employee —the Deceased must have been eligible to retire (age 50 or more with at least 5 years of Service Credits³) at the time of death. ▪ Deceased Disabled Former Employee—the Deceased must have been eligible to retire (age 50 or more with at least 5 years of Service Credits³) at the time of death. ▪ Deceased Retiree —the surviving domestic partner must have been in a relationship with the Deceased for at least one year before the Deceased's retirement date and continuously until the Deceased's death.
Surviving Spouse	<p>The widow or widower of a Deceased. The Surviving Spouse is eligible to receive the survivor welfare benefits without qualifying as an Eligible Spouse under the following conditions:</p> <ul style="list-style-type: none"> ▪ Deceased Employee —the Deceased must have been eligible to retire (age 50 or more with at least 5 years of Service Credits³) at the time of death. ▪ Deceased Disabled Former Employee —the Deceased must have been eligible to retire (age 50 or more with at least 5 years of Service Credits³) at the time of death. ▪ Deceased Retiree —the Surviving Spouse must have been married to the Deceased for at least one year before the Deceased's retirement date and continuously until the Deceased's death.

If Coverage Ends

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

You may be eligible to continue or convert your coverage.

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

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

Appendix C: Benefit Program Materials

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

Medical	Benefit Program Material
Blue Cross Blue Shield of New Mexico	
– National Medicare Supplement (Retirees with Medicare A & B only)	
National EPO	http://www.lanl.gov/worklife/benefits/pdfs/spd_epo.pdf
National PPO (Retirees with or without Medicare)	http://www.lanl.gov/worklife/benefits/pdfs/spd_ppo.pdf
National CDHP (Retirees without Medicare only)	http://www.lanl.gov/worklife/benefits/pdfs/spd_cdhp.pdf
Vision	
Vision	http://www.lanl.gov/worklife/benefits/pdfs/vsp_eoc_2011.pdf
Dental	
Dental	http://www.lanl.gov/worklife/benefits/pdfs/dd_evidence_coverage.pdf
Legal	
Legal Plan (access code 14822ret)	https://www.araglegalcenter.com/home/index.htm
Accidental Death & Dismemberment (AD&D)	
AD&D	http://www.lanl.gov/worklife/benefits/pdfs/add_plan.pdf
Eligibility to Participate	
Eligibility to participate in the LANS Health & Welfare Benefit Plan for Retirees and any Benefit Program	Plan Administrator LANL Benefits Office P. O. Box 1663, MS P280 Los Alamos, NM 87545

Please contact the Benefit Program provider listed in [Appendix E](#) if you do not receive the Benefit Program Summary for the program in which you are enrolled.

Appendix D: Claim and Appeals Administration Information

Please direct all claims and claim appeals to the claims administrator for the Benefit Program in which you are enrolled. Unless otherwise specifically indicated below, the Claims Administrator listed below has full discretionary authority to administer and interpret the Benefit Program in question.

Benefit Program	Claims Administrator
Medical	
Blue Cross and Blue Shield of New Mexico National EPO National PPO National CDHP National Medicare Supplement	Blue Cross and Blue Shield of New Mexico P.O. Box 27630 Albuquerque, NM 87125-7630 1-877-878-5265 http://www.bcbsnm.com/lan/
Vision	
Vision Service Plan (VSP)	Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670 1-800-877-7195 www.vsp.com
Dental	
Delta Dental of California	Delta Dental of California Post Office Box 997330 Sacramento, CA 95899-7330 1-800-777-5854 1-415-972-8300 www.deltadentalca.org/lans
Legal	
ARAG®	ARAG® Post Office Box 9171 Des Moines, IA 50309-9171 1-800-247-4184
Accidental Death & Dismemberment (AD&D)	
The Hartford	Group Benefits The Hartford P.O. Box 2999 Hartford, CT 06104-2999 1-877-878-5265 https://www.thehartfordatwork.com/thaw/

Appendix E: Funding and Contract Administration Information

BENEFIT PROGRAM	TYPE OF FUNDING
Medical	
Blue Cross of California National EPO National PPO National CDHP	self-funded
Dental	
Delta Dental of California	self-funded
Vision	
Vision Service Plan	insured
Accidental Death & Dismemberment (AD&D)	
The Hartford	insured
Legal	
ARAG	insured

Appendix F: Plan Administration Information

Official Plan Name	LANS Welfare Benefit Plan for Retirees (See Appendix C for a listing of Benefit Programs applicable to this SPD).
Employer/Plan Sponsor	Los Alamos National Security, LLC PO Box 1663 MS P280 Los Alamos, NM 87545 (505) 667-1806
Employer I.D. Number (EIN)	20-3104541
Plan Number	502
Type of Administration/ Insurance Issuers	The Benefit Programs are provided under both self-funded and insured arrangements. The insured programs are provided under group contracts between LANS and the carriers. The carriers – not LANS – have full discretionary authority to determine eligibility for benefits, the amount of any benefits payable, and for prescribing the claims procedures for the insured programs.
Plan Funding Medium	The insured arrangements are paid by insurance policies. The benefits and other costs (such as administrative costs) for the self-funded programs are paid from the general assets of LANS.
Plan Administrator	Benefits and Investment Committee Los Alamos National Security, LLC TA-3 Otowi Building 261 2nd Floor PO Box 1663, Mail Stop P280 Los Alamos, NM 87545 (877) 667-1806 or (505) 667-1806
Claims Administrator	See Appendix D
Agent for Service of Legal Process	Registered Agent Attention: LANS Counsel LANS, LLC 4200 West Jemez Road Suite 200B Los Alamos, NM 87545
Plan Year	Generally January 1 – December 31 (2006 Plan Year is June 1 – December 31)
Contribution Sources	LANS and participant contributions

Important Carrier Contact Information

Hewitt Pension Resource (YPR)

Website	http://pension.hewitt.com/losalamos/Login.aspx
Member Services	1-866-370-7301

Hewitt Benefit Resource (YBR)

Website	http://www.ybr.com/benefits/lanl/
Member Services	1-866-934-1200

Blue Cross Blue Shield of New Mexico

Group Number	EPO (N13793; PPO (N13794); CDHP (N13795
Website	http://www.bcbsnm.com/lanl
Member Services	1-505-962-7273

Delta Dental of California

Group Number	4000
Website	www.deltadentalins.com/lans/
Member Services	800-765-6003
Claims Address	PO Box 997330, Sacramento, CA 95899-7330

Vision Service Plan (VSP)

Group Number	12-284390
Member Services	800-877-7195
Claims Address	PO Box 997105, Sacramento, CA 95899-7105

ARAG Legal Plan

Group Number	14822
Website	http://ARGAGLegalCenter.com Then enter Access Code: 14822ret
Member Services	800-247-4184
Address	400 Locust Street, Suite 480, Des Moines, IA 50309

Fidelity Investments (401k and Roth 401k)

Website	https://netbenefits.fidelity.com/
Member Services	800-835-5095