Triad Health and Welfare Plan for Retirees

Summary Plan Description

Revised Effective as of January 1, 2021

IMPORTANT

This Summary Plan Description (SPD) is intended to provide a summary of the principal features of the Triad Health and Welfare 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 Triad National Security, LLC ("Triad") or any affiliated company, or as a guarantee of any rights or benefits under the Plan. Triad, in its sole discretion, reserves the right to amend or terminate in writing at any time the Plan, SPD and/or any Benefit Program, even after retirement. 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, and its terms control.

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: www.lanlbenefits.com.

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Introduction General Information

This Summary Plan Description ("SPD") describes the Benefit Programs (defined below) sponsored by Triad National Security, LLC ("Triad") and made available to eligible retirees of Triad through the Triad Health and Welfare 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.

Triad 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, domestic partners, and certain 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.

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 SPD specified where the term first appears.

It is the policy and intent of Triad to comply with all applicable provisions of the Affordable Care Act. Triad will investigate fully any complaint that it or the Plan has not complied with such laws and will take steps to remedy any violations should they occur. If you believe that it or the Plan has violated a provision of the Affordable Care Act, you are encouraged to contact the Plan Administrator at (877) 667-1806 or (505) 667-1806 or at the address provided at the end of this document to share your complaint. Please provide as much information as you can regarding your complaint to help Triad with its investigation. Triad will not retaliate or otherwise discriminate against you if you assert a complaint or take any other action which is protected under the Affordable Care Act.

SBCs: Each medical benefit option also has a Summary of Benefits and Coverage (SBC) located on the LANL Benefits Website. The SBC is based on a template required by the federal government so individuals can easily compare medical options. While the SBCs are concise "snapshots" of the options, they are not intended to take the place of your Summary Plan Description (SPD) or the official plan document. Your eligibility and benefits will only be determined in accordance with and subject to the official plan documents and the applicable SPD.

Additional Rules Extending Certain Deadlines As a Result of COVID-19

Last year, the U.S. Department of Labor and the Department of Treasury announced a temporary extension of various ERISA and COBRA deadlines and time periods which ordinarily apply to employee benefit programs on account of the COVID-19 National Emergency. Under this extension, the deadlines and time periods that apply to individuals for taking the actions described below are suspended during the period that began on March 1, 2020, and extends until 60 days following the announced end of the COVID-19 National Emergency (the "Outbreak Period"). However, the government has announced that this suspension period may not last longer than one year with respect to a particular deadline that applies to an individual. This means that your deadline for taking action will not be extended for longer than one year, but it may be extended for a shorter period depending on when the President declares an end to the National Emergency.

The period during which these deadlines and time periods are extended is referred to as the "COVID-19 Extension Period." The COVID-19 Extension Period is the earlier of one year from the date you are first eligible for the suspension with respect to a particular deadline or the end of the Outbreak Period.

Extension of the Claims and Appeals Deadlines for All ERISA Plans

The Plan will disregard the COVID-19 Extension Period when determining whether a participant or beneficiary (or an authorized representative) has timely filed a claim for benefits or an appeal of an adverse benefit determination under the Plan's claims procedures. This means that the time period for filing a claim or an appeal under the Plan's claims procedures will be suspended during the COVID-19 Extension Period and will begin running again once the COVID-19 Extension Period ends.

Extension of COBRA Continuation Coverage Deadlines

Certain COBRA continuation coverage deadlines will be extended during the COVID-19 Extension Period. The Plan will disregard the COVID-19 Extension Period when determining whether a qualified beneficiary has timely satisfied the following deadlines relating to COBRA coverage:

- *Notice of Initial COBRA Qualifying Event:* The 60-day deadline for providing notice of an initial COBRA qualifying event, such as divorce or a dependent aging out of the plan;
- *COBRA Coverage Election:* The 60-day deadline for electing COBRA continuation coverage; and
- *COBRA Premium Payment*: The 45-day (initial payment) and 30-day (ongoing payments) deadline for paying for COBRA continuation coverage.

This means that the time period for taking any of the COBRA-related actions described above will be suspended during the COVID-19 Extension Period and will begin running again once the COVID-19 Extension Period ends. Please keep in mind that delaying

notice or payment will not change the effective date of your COBRA coverage, and you will still be required to make up each of the missed payments.

Extension of HIPAA Special Enrollment Deadlines

The Medical Plan will disregard the COVID-19 Extension Period when determining whether you have timely enrolled your dependent following a HIPAA special enrollment event, to the extent those rights apply to you. A HIPAA special enrollment event may include acquisition of a new dependent on account of marriage, birth or adoption. This means that the time period for enrolling in the Medical Plan following a HIPAA special enrollment event will be suspended during the COVID-19 Extension Period and will begin running again once the COVID-19 Extension Period ends.
Keep in mind, however, that coverage may not be retroactive (except for birth or adoption) and that the deadline for making any other changes are not extended, including with respect to other election events that are not special enrollment rights under federal law.

Extension of External Review Deadlines

The Medical Plan will disregard the COVID-19 Extension Period when determining whether a participant has timely requested external review of a denied claim or completed a request for external review. To complete a request for external review, the participant may be required to provide additional information to the reviewer. More information is provided in the medical plan booklets regarding how and when you may file a request for external review. This means that the time period for requesting (or completed a request for) external review will be suspended during the COVID-19 Extension Period and will begin running again once the COVID-19 Extension Period ends.

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 Plan administration information

Appendix G for Insurance Carrier Contact Information

Triad Benefit Programs

"Benefit Programs" means all welfare benefit programs and plans maintained by Triad for its retirees and/or their family members under the Plan.

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

Triad Medical Program (including prescription drug coverage)

Triad Dental Program

Triad Vision Program

Triad Voluntary AD&D Program

Triad Legal Program

The Benefit Programs offered under the Plan may change from time to time. Details for these Benefit Programs are described in separate booklets or certificates as described in Appendix C.

Keep Your Records Updated

Make sure that the Triad 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 Empyrean Customer Care Center for LANL (contact information in Appendix G) to update your personal information, such as your home address and home telephone number.

1. 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 determine if you are eligible to be covered under the Plan.

Please see Appendix A for information about service credit and how it relates to the employer subsidy under this Plan.

Retiree Health and Welfare Benefit Eligibility

To qualify for Plan benefits (medical, dental, vision, AD&D and legal), you must be included in one of the following categories and meet 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 Los Alamos National Security, LLC ("LANS") or Triad who is a UC Transitioning Employee[1] who properly elected TCP1, who has 5 years of Service Credits and is eligible to receive a monthly disability benefit under the Triad Defined Benefit Eligible Disability Program (formerly the LANS Defined Benefit Eligible Disability Program); or

Category D. A former LANS employee who retired from a benefits eligible appointment at LANS between June 1, 2006 and October 31, 2018 or who retires from a benefits eligible appointment at Triad on or after November 1, 2018 and who is:

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

2. a UC Transitioning Employee[1], who (i) properly elected TCP2 who is receiving a monthly pension from the UCRP, or (ii) properly elected TCP2 but was not vested in his/her benefit from the UCRP on June 1, 2006; or

3. a Direct Transfer Employee[2] hired by LANS between June 1, 2006 and October 31, 2018; or

Category E. Be a (1) a LANS employee hired between June 1, 2006 and October 31, 2018, (2) a UC Transitioning Employee1 who elected TCP2 and who took a lump sum distribution of his/her UCRP pension benefit, or (3) a Triad employee hired on or after November 1, 2018.

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

1. either

   i. if you terminate service with Triad on or after November 1, 2018, you must have been covered under the medical plan maintained by Triad for its active employees as of the date of your termination from Triad, or

   ii. if you terminated service with LANS between June 1, 2006 and October 31, 2018, you must have been covered under the medical plan maintained by LANS for its active employees as of the date of your termination from LANS; and

[1] A UC Transitioning Employee means an individual who became employed by 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 or directly from an Affiliate of a LANS Parent Company from June 1, 2006 through October 31, 2018. A LANS Parent Company means UC (excluding UC-LANL), Bechtel, BWXT (Babcock & Wilcox), and the Washington Group (URS, Washington Division). An Affiliate of a LANS Parent Company is any company partially or fully owned by a LANS Parent Company.

2. actively enroll in the Plan within 120 days of your termination from Triad (if on or after November 1, 2018) or LANS (if between June 1, 2006 and October 31, 2018); and

3. either

   i. be at least age 50 with at least 10 years of applicable Service Credits on the date of your termination from Triad (if on or after November 1, 2018) or LANS (if between June 1, 2006 and October 31, 2018); or

   ii. be at least age 50 on the date of your termination from Triad (if on or after November 1, 2018) or LANS (if between June 1, 2006 and October 31, 2018), 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 G.

Service Credits for Eligibility for Retiree Welfare Benefits

Service Credits means years of service, as determined by the Plan Administrator, with Triad on or after November 1, 2018. Service Credits also include years of service recognized for a Triad Direct Transfer Employee by the transferring entity as of the date of transfer to Triad on or after November 1, 2018.[4]

If you elected a lump sum payment from the UCRP, then your Service Credits shall not include any years of service attributable to service you earned before June 1, 2006. However, any service you earn on or after June 1, 2006 will be included in your service credit calculation.

Years of service with Triad (formerly LANS) are computed by following the methodology used to calculate a "Period of Service" under the Triad Defined Benefit Pension Plan (formerly 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 Triad Defined Benefit Pension Plan (formerly the LANS Defined Benefit Pension Plan). Only whole year increments (rounded down) will count toward Retiree Medical eligibility (i.e., 14.73 years will be 14). The following table shows generally how Service Credits are computed for each category above:

Category of Retiree	Service Credits for Eligibility for Retiree Welfare Benefits
A	Service Credits are based on years of service with UC.
B	Service Credits are based on years of service with UC.

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

[4] A Triad Direct Transfer Employee means an employee of Triad who was transferred to Triad on or after November 1, 2018 directly from a Triad Parent Company that performed service for the Department of Energy or the National Nuclear Security Administration under a Management and Operating or Site Management Contract. A Triad Parent Company includes the University of California, the Texas A&M University System, and Battelle Memorial Institute.

C	Service Credits are based on years of service with UC transferred to LANS on June 1, 2006, years of service at LANS from June 1, 2006 through October 31, 2018, and years of service at Triad beginning November 1, 2018.
D.1	Service Credits are based on years of service with UC transferred to LANS on June 1, 2006, years of service at LANS from June 1, 2006 through October 31, 2018, and years of service at Triad beginning November 1, 2018.
D.2	Service Credits are based on years of service with UC transferred to LANS on June 1, 2006, years of service at LANS from June 1, 2006 through October 31, 2018 and years of service at Triad beginning November 1, 2018.
D.3	From June 1, 2006 through October 31, 2018, 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. On or after November 1, 2018, Service Credits are based on years of service at Triad.
E.	Service Credits are based on years of service at LANS from June 1, 2006 through October 31, 2018 and years of service at Triad beginning November 1, 2018.

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.

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; or
- your domestic partner, subject to the rules provided at enrollment; or

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

You may have only one eligible adult family member enrolled in your Triad-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 domestic partner's child	Medical, Dental, Vision, Legal	Through the end of the month in which the child attains age 26	Only unmarried children are eligible for Legal
Legal ward	Medical, Dental, Vision, Legal	To age 18	• unmarried • living with you • supported by you (50%+) and claimed as your tax dependent
Child	**Plan**	**Eligibility**	**Must meet all applicable requirements**

Overage disabled child (as defined above, but not including a legal ward) of employee	Medical, Dental, Vision, Legal	No age restriction	• unmarried • covered under the Triad group medical benefit program before age 26 and the incapacity must have begun before age 26. (Exception: A new hire at Triad on or after November 1, 2018 (or LANS between June 1, 2006 and October 31, 2018), who is not a UC Transitioning Employee[5] may enroll an overage disabled child without any prior continuous group medical coverage) • once eligible and enrolled, continuous coverage under a Triad 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 • medical certification must be provided in the time and manner requested (periodic recertification may be requested)

Your disabled child age 26 or older is still considered to be your eligible child and not an adult. You may enroll your domestic partner's child even if you do not enroll your domestic partner.

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

Ineligible Persons

Employees covered by a collective bargaining agreement, except as otherwise provided in such agreement.

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

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.

You can get a copy of the Plan's QMCSO procedures upon request to the Plan Administrator listed in Appendix F 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.

No Duplicate Coverage

Plan rules do not allow duplicate coverage. This means you may not be covered in any Triad-sponsored program as a retiree and as an employee or as an eligible family member of more than one Triad employee or retiree at the same time. If you are covered as a family member and then become eligible for Triad 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 Triad employee or retiree who has been covering you de-enrolls you from his or her Triad-sponsored program before you enroll yourself.

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

In addition, Triad 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 the Benefit Program and you or that other person is ineligible to participate in that program or you fail to properly notify Triad that you or your family member is no longer eligible to participate, Triad will de-enroll the ineligible participant once Triad 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 Triad of the divorce.
- you (or the covered individual) have 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 domestic partner at the time you enrolled, as your 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 Triad with falsified or counterfeit documents to show eligibility.
- Failure to provide documentation to determine eligibility in a timely manner when requested by Triad.

In situations other than those described above to the extent required by law with respect to the Medical Program, Triad will provide you with 30 days advance written notice that you or another person enrolled as your family member will be de-enrolled and Triad 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 Triad 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 may be subject to disciplinary action including, but not limited to, Triad de-enrolling you from coverage under the Plan.

Loss of Family Member Eligibility

When you or any other family member no longer meets the eligibility requirements to participate in one or more Triad-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 Empyrean Customer Care Center for LANL at the member service number provided in Appendix G. If you do not, you are liable for any excess Triad costs and for any Benefit Program expenses incurred by the ineligible family member. Premiums will not be refunded retroactively if you did not contact the Empyrean Customer Care Center for LANL to remove the ineligible family member from coverage in a timely manner. See "Ineligible Persons" in this section for more details about eligibility requirements. In addition, failure to provide timely notice may result in the loss of eligibility for COBRA coverage (see the COBRA section below for information) but also refer to the special rules during the pandemic as described in the introduction.

Rehired Retirees

If you return to work for Triad after retirement and are hired into a position eligible for employee medical benefits, your coverage under the Plan will be suspended until your Triad 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, Triad requires each retiree, disabled member*, and enrolled family member who is eligible, to enroll, and remain enrolled, in Medicare Part A and Part B *when first eligible for any Medicare program or, if later, upon termination of coverage under Triad's medical plan for active employees).* 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 Triad Medical Program.

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

Medicare Part D:

Each retiree, disabled member and enrolled family member enrolled in any **Triad 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 were 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 Triad Medical Program which is subject to change from year to year.

3. How to Enroll

Retiree Benefits

At the time you become eligible for retiree benefits, Empyrean will mail information on how to enroll in Triad Medical, Dental, Vision, Legal Program benefits to the home address on file with Triad. If you choose to enroll in AD&D benefits, you will need to contact the Service Provider directly. If you need information on enrolling, please contact the LANL Benefits Office at (877) 667-1806 or (505) 667-1806.

See Appendix G for Service Provider and Insurance Carrier Contact Information.

If you do not wish to enroll in the Triad 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 Triad.

You must actively enroll within 120 days of your termination from Triad, 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 Triad Medical, Dental or Vision Programs, please contact the Empyrean Customer Care Center for LANL at the member services number listed in Appendix G.

Period of Initial Eligibility (PIE)

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

A PIE starts on the "event date" and ends 31 days later (except that you must actively enroll within 120 days of your termination from Triad). 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 Triad 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.

Electing No Coverage for Medical, Dental, Vision or Legal Coverage - A retiree or surviving family member may suspend enrollment in Triad Medical, Dental, Vision, 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 Triad Benefit Programs upon the occurrence of an Involuntary Loss of Other Coverage (ILOC) as described in Section 7, "Making Changes to Your Medical, Dental, Vision or Legal Programs Elections". You will have a new PIE (as described above) in which to enroll in a Triad-sponsored Medical, Dental, Vision, or Legal Benefit Program.

Suspending Medical Coverage

To suspend coverage under Triad Medical Program, a retiree or survivor must contact the Empyrean Customer Care Center for LANL.

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

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

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

Open Enrollment. You may re-enroll in the Triad 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-Triad Medicare Part D coverage. If you have non-Triad Medicare Part D coverage, you are not eligible for any Triad medical benefits. See Section 2, "Eligibility Requirements, Mandated Medicare — Your Responsibility."

Involuntary Loss of Other Coverage. You may re-enroll in the Triad 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 Triad Medical Program. Your Triad 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, unless Triad requires an active enrollment for that Plan Year. Any required active enrollment will be communicated in the annual enrollment material.

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 Triad. 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.

4. Paying for Coverage

You and Triad share the cost of coverage under certain Benefit Programs, as described in Appendix A. Triad 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 Empyrean in Appendix G for coverage under the Medical and Dental Programs and by direct payment to the Triad Legal, Vision and AD&D Programs listed in Appendix G.

If a change is made to retiree coverage in the Triad 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 Triad Vision, 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.

Triad Contributions

Triad contributions for benefits are generally not taxable income to retirees (but see below).

Imputed Income

The value of coverage provided by Triad 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:

- domestic partners and their children
- grandfathered adult dependent relatives

Federal Tax Rules For Tax-Favored Health Benefits

Family Members who are otherwise eligible for coverage under a Medical, Dental and Vision 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 26.
- "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.
  - Certain individuals who share your residence as a member of your household for the entire year, 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.

Please contact the LANL Benefits Office if you have questions concerning a domestic partner, dependent child or other dependent status issue. Typically domestic partners and their children do not qualify as tax dependents.

5. Health Program Information

The Plan includes "health" Benefit Programs including 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 G.

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 G.

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 higher 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, and some programs may not cover services by out-of-network providers, except in very limited situations, such as an emergency.

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

6. Other Benefits

Benefit Program Material

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; and
- procedures available for the review of denied claims.

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

Legal Benefit Program

The Triad Legal Benefit Program provides basic legal services for eligible retired employees and their eligible family members.

Employees who terminate employment and retire with Triad 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 G 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 G.

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 Empyrean Customer Care Center for LANL in Appendix G 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 until 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.
- **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:
    - o beginning or terminating employment
    - o 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 Empyrean Customer Care Center for LANL. See Appendix G for contact information.

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 Empyrean Customer Care Center for LANL 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 Triad adds, eliminates or significantly reduces an option under a Benefit Program in the middle of the Plan year, or if Triad-sponsored coverage is significantly limited or ends, you and your family members may be eligible to elect different coverage.

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 Triad adds another option under a particular Benefit Program mid-year, participants can drop their existing coverage and enroll in the new option.
- 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 an option under a Benefit Program in which you are enrolled during the Plan year, you may enroll in that option.

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.

Triad 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 Triad 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 Triad health plan within 31 days of the loss of coverage.

Acquiring New Family Members

When you acquire a newly eligible child (through marriage, birth, adoption, or placement for adoption), you may enroll yourself, and your eligible children in the Triad medical coverage within 31 days of the date you acquire the new family member. Your spouse or domestic partner is only eligible for survivorship benefits under the Plan if he or she was your spouse or domestic partner for at least one year before the commencement of your pension and is named as a contingent annuitant for your pension benefit.

For newly acquired 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 and Enrolling in Medicare

Medicare Entitlement

You are required to enroll in Medicare Parts A and B as soon as you are eligible to do so. Failure to do so may affect your coverage under the Plan.

Judgment, Decree or Order

You may revoke an election for medical coverage mid-year and make a new election if a judgment, decree, or order requires medical 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 Triad Medical Program election to provide coverage for the eligible child if the order requires coverage under your Triad 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-Triad medical benefit program may be provided an opportunity to enroll in a Triad Medical Program. Contact the Empyrean Customer Service Center for LANL at the member service number provided in Appendix G.

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 domestic partner or your domestic partner's tax dependent. Therefore, you may add or drop a domestic partner from coverage during the year if an event occurs which would allow a mid-year change in election.

8. Claims and Appeals Procedures and Required Arbitration

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 SPD directly to the Claims Administrator for that specific benefit. See Appendix D for a list of Claims Administrators.

With respect to claims regarding eligibility or claims that are not subject to the claims procedures set forth in the applicable Benefit Programs, the following procedures will apply:

Any claims for eligibility under the Plan or other non-benefit claims must be filed with the Plan Administrator through the Empyrean Customer Care Center for LANL. The Plan Administrator will respond to all such claims within the time frames that apply for benefit claims under the applicable Benefit Program.

If a claim regarding eligibility or other claim other than a claim for benefits is denied in whole or in part (this is an adverse benefit determination) and the claimant wants the decision reconsidered, an appeal of such claims must be filed with the Benefits Appeals Committee within 60 calendar days of the denial. The Benefits Appeals Committee will respond to all such appeals, generally within the time frames that apply for benefit claims under the applicable Benefit Program. The appeal to the BAC must be addressed to:

Benefits Appeals Committee Triad National Security, LLC
c/o Plan Administrator - Triad Welfare Plan For Retirees
P.O. Box 1663, MS P280 Los Alamos, NM 87545

Any claim or appeal for a specific benefit shall be made in accordance with the applicable insurance policy or Benefit Program material (typically the Claims Administrator for that specific benefit). See Appendix C for Claims Administrators. In the event Appendix C identifies the Plan Administrator as the Claims Administrator, the Claims Procedures set forth in this Section apply.

Please see below for more information on the requirement that the claims procedures of the Benefit Program must be fully exhausted in order to have a right to pursue such claim through mandatory arbitration.

The claims procedures for each specific Benefit Program are provided in the plan material and will be furnished to you upon request 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.

Exhaustion of Claims Procedures Required

An adverse benefit determination will include a description of the Plan's review procedures and the time limits applicable to your ability to submit a dispute to arbitration (in lieu of a civil action under Section 502(a) of ERISA).

The Plan and each Benefit Program require that the administrative procedures be exhausted before proceeding with arbitration or, if applicable, a legal claim. This exhaustion requirement applies: (1) regardless of whether other claims, assertions, allegations, disputes, issues, actions or other matters (including those that a court might consider at the same time) are of greater significance or relevance; (2) to any rights the Plan Administrator may choose to provide in connection with novel claims or in particular situations; (3) regardless of whether the rights are actual or potential; and (4) even if the Plan Administrator has not previously defined or established specific claims procedures that directly apply to the submission and consideration of a claim (in which case the Plan Administrator, upon notice of the claim, shall either promptly establish such claims procedures or shall apply or act by analogy to the claims procedures that otherwise apply to claims for benefits).

For purposes of this exhaustion requirement and for the appeals procedures, a "claim" is any claim, matter, issue, action, allegation, assertion, or other dispute that involves any one or more of the following:

- The interpretation of the Plan;
- The interpretation of any term or condition of the Plan;
- The interpretation of the Plan (or any of its terms or conditions) in light of applicable law;
- Whether the Plan or any term or condition under the Plan has been validly adopted or put into effect;
- The administration of the Plan;
- Whether the Plan, in whole or in part, has violated any terms, conditions or requirements of ERISA or other applicable law or regulation, regardless of whether such terms, conditions or requirements are, in whole or in part, incorporated into the terms, conditions or requirements of the Plan;
- A request for Plan benefits or an attempt to recover Plan benefits;
- An assertion that any entity or individual has breached any fiduciary duty;
- An assertion that any individual or entity is a participant, former participant, Plan beneficiary, former Plan beneficiary or assignee of any of the foregoing; or
- Any claim, matter, issue, action, allegation, assertion or other dispute that (i) is deemed similar to any of the above items by the Plan Administrator, or (ii) relates to the Plan in any way.

The term "Plan" above includes reference to each Benefit Program under the Plan.

Important Rules Regarding Limitations on Actions and Required Arbitration Instead of Legal Action:

Effective as of January 1, 2019, in accordance with the change in Employer from Los Alamos National Security, LLC to Triad National Security, LLC, after exhausting the applicable administrative remedies (including the right to appeal), any dispute arising out of or in any way related to the Plan or any Benefit

Program (including but not limited to any claim relating to eligibility to participate or the amount of benefits) must be settled by binding arbitration to the fullest extent permitted by law, which must be brought in accordance with this provision and the American Arbitration Association's Employment Rules and Mediation Procedures in effect at the time a demand for arbitration is filed, whether or not you have had a termination of employment. The Plan Administrator will provide you a copy of such rules and procedures without charge upon request. The arbitration will be determined solely on the record established for the appeal (unless the claims procedure is determined not to apply to the dispute). You must bring any dispute in arbitration on an individual basis only, and not on a class, collective or representative basis. By claiming eligibility to participate in the Plan, or by actual participation, you waive the right to commence, be a party to, or be an actual or putative class member of any class, collective, or representative action arising out of or relating to the Plan ("class action waiver"). These requirements apply to all active, inactive and retired Plan members regardless of whether you are, or were, employed by LANS or Triad. However, if this class action waiver is found to be unenforceable by a court of competent jurisdiction, then any claim on a class, collective, or representative basis must be filed and adjudicated in the United States District Court for the District of New Mexico, and not in arbitration. Except as provided in the preceding sentence, this section is intended to make mandatory individual arbitration apply, as described above, to the maximum extent permissible under ERISA; if any feature of this arbitration requirement is impermissible under ERISA, arbitration as described above shall remain required with the minimum change necessary to allow the arbitration requirement to be permissible under ERISA.

Following exhaustion of administrative remedies, including an appeal of the initial determination, you must submit the dispute to arbitration within twelve (12) months of the date of the notice to you of the final decision on the appeal. Any claim or action not brought within this time period is null and void. Following the arbitrator's decision, you may only submit a dispute to the court (which for this purpose must be filed and adjudicated in the United States District Court for the District of New Mexico) with respect to the decision of the arbitrator to the extent permitted by law, and then, only within ninety (90) days of the date of the arbitrator's issuance of a final decision or such other period under applicable law.

If it is determined that the arbitration provisions do not apply, you may not submit a dispute to a court with respect to a denied claim under this Plan prior to exhausting the Claims and Appeal Procedure or more than one year after the date the Benefit Appeals Committee renders its final decision upon appeal. Any claim, suit or action filed in court or any other tribunal in connection with the Plan may only be brought or filed in the United States District Court for the District of New Mexico. Claims cannot be filed until the claims procedures have been fully exhausted.

Upon review by any arbitrator, court or other tribunal, the exhaustion requirement is intended to be interpreted to require exhaustion in as many circumstances as possible. In any action or consideration of a claim in arbitration or court or in another tribunal following exhaustion of the plan's claims procedures, the subsequent action or consideration shall be limited to the maximum extent permissible to the record that was before the applicable claims fiduciary in the claims procedure process.

Health Benefit Claims and Appeals Procedures

Filing an Initial Claim

You must follow the claims procedures established by the various health Benefit Programs (medical, dental, vision). 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 for details on filing claims. Claims for eligibility are subject to the similar procedures as claims for benefits except

that they are filed and determined by the Plan Administrator (and appeals of such claims are filed with the Benefits Appeals Committee), and different time frames may apply.

Appeal of Adverse Decision
If you disagree with the decision on your claim including for a request or application for participation and you want your claim reconsidered, you (or your authorized representative) must file a written appeal with the applicable Claims Administrator within 180 days after your receipt of the notice of adverse decision. If you don't appeal on time, you may lose your right to file an action in arbitration (or, if required by law, other legal action), as you will not have exhausted your internal administrative appeal rights. For decision on eligibility to participate, the appeal must be filed with the Benefits Appeals Committee within 60 days after you receive the initial notice of adverse decision.

For appeals of adverse benefits decisions involving Urgent Care Claims, the Claims Administrator will accept either oral or written requests for appeals for an expedited review. All necessary information may be transmitted between the Claims Administrator and you or health program providers by telephone, fax or other available expeditious methods.

Notice of Decision on Appeal
After your appeal is reviewed by the Claims Administrator (or Benefits Appeals Committee, as applicable), you will receive a notice of decision on appeal within the timeframes specified in the applicable Benefit Program material for details on filing claims and in accordance with ERISA.

The timeframes for providing a notice of decision on appeal generally start when a written appeal is received by the Claims Administrator (or Benefits Appeals Committee for eligibility claims). Notice of decision on appeal may be provided in writing through mail, or electronic delivery. Urgent Care Claims decisions may be delivered by telephone, facsimile, or other expeditious methods. "Days" means calendar (not business) days.

Your Right to Information
Upon request to the applicable Claims Administrator, 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 Administrators denial of a claim or appeal. Information is "relevant" if it:

- was relied upon in making the decision on your claim or appeal;
- was submitted to, considered, or generated by the Claims Administrator in considering your claim or appeal; or
- demonstrates compliance with the Claims Administrator's administrative processes for making claim decisions.

You are also entitled to access and copy any internal rule, guideline, protocol, or other similar criteria used as a basis for a decision on your denied claim or appeal upon request, free of charge. Similarly, if your claim or appeal is denied based on a determination involving a medical judgment, you are entitled to an explanation of the scientific or clinical reasons for that determination free of charge upon request. (A medical judgment includes whether a treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate.) In addition, if voluntary appeals or alternative dispute resolution options are available under the Benefit Program, you are entitled to receive information about the procedures for using these alternatives.

Non-Health Benefit Claims and Appeals Procedures

Filing an Initial Claim

You (or your beneficiaries) must follow the claims and appeal rules established by the various non-health Benefit Programs (legal and AD&D) with respect to a claim for benefits. If you are required to file an initial claim for benefits, you must do so within the time specified by the Benefit Program and in accordance with the program's established claim procedures. See the applicable Benefit Program material for details on filing claims.

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 D.

Adverse Decision or Adverse Decision on Appeal. A denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a benefit or to deny eligibility for coverage.

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 applicable Claims Administrator listed in Appendix D.

9. Continuation of Health Care Coverage

COBRA Continuation Coverage

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

COBRA coverage is available in certain instances, called "qualifying events," where health Benefit Program coverage would otherwise end. You may elect to continue coverage at your own expense on an after-tax basis when the coverage that you have through the Plan ends. The coverage described below may change as permitted or required by changes in any applicable law.

The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of COBRA. In some states, state law provisions may also apply to the insurers offering benefits under the Plan.

You don't have to show that you're insurable to choose COBRA coverage. However, COBRA coverage is provided subject to your eligibility for coverage as described below. Triad reserves the right to terminate your coverage, even retroactively, if it's determined that you're ineligible under the terms of the Plan.

When making the decision of whether to elect COBRA continuation coverage, you should consider that there may be other coverage options for you and your family. For example, you may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away. Being eligible for COBRA does not limit your eligibility for this coverage or a tax credit through the Marketplace. However, once you elect COBRA, these options are affected.

If you elect COBRA coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period (if you are eligible for such coverage). You can also end your COBRA coverage early and switch to a Marketplace plan (if eligible) if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." If, however, you terminate your COBRA coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim. Marketplace coverage may not be available to those covered by Medicare.

Once you've exhausted your COBRA coverage and the coverage expires, you may be eligible to enroll in Marketplace coverage through a special enrollment period, even if you enroll outside of the Marketplace open enrollment. Before you make a decision to enroll in coverage offered through the Marketplace, you can see what premiums, deductibles and out-of-pocket costs will be. You should compare plans so that you can see which coverage is right for you. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days of the date your coverage ends. It is your responsibility to determine what coverage you may be eligible for, including through the Marketplace.

Cost of COBRA Coverage

You will be required to pay up to 102% of the cost of COBRA coverage.

The cost of group health coverage periodically changes. If you elect COBRA coverage, the COBRA Administrator will notify you of changes in the cost. Premiums are established in a 12-month determination period and will increase during that period if the Plan has been charging less than the maximum permissible amount, or if the qualified beneficiary changes coverage level.

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

COBRA Administrator

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

You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website at www.dol.gov/ebsa.

Your Obligation to Notify the COBRA Administrator

You must notify the COBRA Administrator in writing immediately if:

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

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

Who is eligible for COBRA?

Spouses

If you are the legal spouse of a retiree and you're covered by a health Benefit Program on the day before the qualifying event, you're considered a qualified beneficiary. That means you have the right to choose COBRA coverage for yourself if you lose coverage under the terms of the health Benefit Program for any of the following reasons:

- your spouse dies; or

- you divorce or legally separate from your spouse (this includes a divorce or legal separation that occurs after the employee drops you from coverage, if the employee acted in anticipation of the divorce or legal separation).

Dependent children

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

- the retiree (your parent) dies; or

- you cease to be a "dependent child" under the health Benefit Program.

Chapter 11 Bankruptcy

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

Continuation Coverage for Domestic Partners

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

- "Spouse" is used and wherever "qualified beneficiary" when referring to a spouse is used, the term "domestic partner" as defined by the Plan also generally applies.

- Wherever the terms "dependent child" or "dependent children" are used, or wherever "qualified beneficiary (ies)" when referring to a dependent child or dependent children is used, the dependent child/children of a domestic partner also generally applies.

- Wherever the term "divorce" is used, termination of domestic partnership also generally applies.

- Wherever the term "COBRA continuation coverage" is used, continuation coverage also generally applies.

Your duties

You must inform the COBRA Administrator of a divorce, legal separation, termination of domestic partnership, or child's loss of dependent status under the health Benefit Program in

writing if you wish to preserve their right to elect COBRA coverage. You must provide notice within 60 days from the latest of (1) the date of the divorce, legal separation, termination of domestic partnership, or loss of dependent status, or (2) the date coverage is lost because of the event.

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

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

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

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

Triad's duties

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

- the retiree dies; or
- Triad experiences a bankruptcy.

Electing COBRA

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

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

If you choose COBRA coverage, your coverage will be the same coverage you had immediately before the event and the same coverage that is being provided to similarly situated beneficiaries. "Similarly situated" refers to a current retiree or dependent who hasn't had a qualifying event.

You'll have the same opportunity to change health Benefit Program coverage as similarly situated retirees have, e.g., at annual open enrollment or if you gain a new dependent.

This also means that if the coverage for similarly situated retirees or family members is modified, your coverage will be modified.

Separate elections

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

Length of COBRA coverage

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

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

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

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

Early termination of COBRA coverage

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

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

- the qualified beneficiary first becomes entitled to Medicare after the date COBRA coverage is elected.

Benefit Program Changes During COBRA

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

For More Information

This notice does not fully describe the continuation coverage under the Plan. More information about continuation coverage and Your rights under this Plan is available from the Plan Administrator.

If you have any questions concerning the information in this notice or your rights to coverage, You should contact Triad. To protect your rights, keep the Plan Administrator informed of any changes in your or your family member's addresses. You should also keep a copy of any notices you send the Plan Administrator or COBRA Administrator.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at http://www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit ***www.healthcare.gov***.

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 Triad 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 Claims Administrator at the member service number provided in Appendix G.

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

Here's how it works in general:

When the Triad-sponsored program pays first, in other words, if the Triad-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 Triad-sponsored program pays second, in other words, if the Triad-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 Triad 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, LANS, or Triad.

- Social Security disabled individuals who are covered by the Plan on the basis of retiree's former employment status with UC, LANS or Triad 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 Triad 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 Triad receives payments with respect to a Part D-eligible individual in Triad'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 were 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 a retiree, the allocation made to your account, or the amount of benefits paid or to be paid 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 Triad from compensation paid by Triad or offsetting any benefits you may be entitled to.

Plan Amendment and Termination

Triad 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, even after your retirement. Triad's decision to amend or terminate is not a fiduciary decision. It is a business decision that can be made solely in Triad's interest.

Triad or its authorized delegate may terminate or partially terminate the Plan, or discontinue contributions at any time. In addition, Triad 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. Triad 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 Triad.

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.

Triad 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 Triad, the Plan Administrator or any employee, officer or director of Triad.

Contributions and Premiums

Triad's Contributions

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

Self-Funded Benefits

Triad's general assets are the sole source of self-funded benefits under the Plan. Triad 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 Triad, the Plan, any Benefit Program or any underlying contract, trust or other funding vehicle.

Recovery Provisions

Refund of Overpayments

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these excess payments from any individual (including you or your Dependents), insurance company, provider, or other entity to whom the excess payments were made or to withhold payment, if necessary, on future benefits until the overpayment is recovered.

If excess payments were made for services rendered to you or your Dependent, the Plan has the right to withhold payment on future benefits until the overpayment is recovered. In addition, if an overpayment has occurred, you or your Dependent, as applicable, grant the Plan a first priority equitable lien in such payment to the extent it can be identified.

Further, whenever payments have been made based on fraudulent information provided by you or your Dependent, the Plan will exercise all available legal rights, including its right to withhold payment on future benefits until the overpayment is recovered

Acts of Third Parties and Reimbursement Rights of the Plan

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 D may cover your eligible health care (medical, prescription drug, dental and vision) expenses but the Plan will be entitled to reimbursement for any payments it has made with respect to such illness or injury. To receive coverage, you must notify the Claims Administrator listed in Appendix D that your illness or injury was caused by a third party, and you must follow any special Claims Administrator or Plan rules. You or your dependent (or the legal representatives, estate or heirs of either you or your dependent), must promptly reimburse the Plan for any benefits it has paid relating to that illness or injury, up to the full amount of the compensation received from the other party, regardless of how that compensation may be characterized (e.g., the Plan is entitled to recover from the third party even if the settlement or judgment is designated as for pain and suffering, for non-economic damages or for non-medical expenses) and regardless of whether you or your dependent have been made whole. If the Plan has not yet paid benefits relating to that illness or injury, the Plan may reduce or deny future benefits on the basis of the compensation received by you or your dependent.

This section describes the Plan's procedures with respect to subrogation and right of recovery.

Subrogation

The right of subrogation means the Plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan is subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate

action to assert its subrogation claim, with or without your consent. The Plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery. This right of reimbursement is in addition to the right of subrogation described above.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you (and anyone acting on your behalf) will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of the person's duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan.

Assignment

In order to secure the Plan's recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the Plan, you acknowledge that the Plan's recovery rights are a first priority claim and are to be repaid to the Plan before you receive any recovery for your damages. The Plan is entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. In addition, the Plan rejects the "common-fund doctrine" and any other similar rule which would require the Plan to share in the recovery costs. The Plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of these subrogation and right of recovery provisions apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the Plan provided or purports to allocate any portion of such

settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's right of subrogation and right of recovery apply without regard to any equitable defenses that you assert or may be entitled to assert, including without limitation any defense of unjust enrichment. The Plan's rights will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is your duty to notify the Plan promptly when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the plan or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of your health benefits or the institution of proceedings against you.

You agree not to do anything to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of these provisions. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the Plan's subrogation and reimbursement interest. Further, you agree to execute such documents as may be required to secure the Plan's subrogation rights.

You acknowledge that the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

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

If the subrogation provisions in these "Acts of Third Party" provisions conflict with subrogation provisions in an insurance contract governing benefits at issue, the subrogation provisions in the insurance contract will govern. If the right of recovery provisions in these "Acts of Third Party" provisions conflict with right of recovery provisions in an insurance contract governing benefits at issue, the right of recovery provisions in the insurance contract will govern. All Plan rights under this section remain enforceable against the heirs and estate of any covered person.

No Estoppel of Plan

No person is entitled to any benefit under the Plan or any Benefit Program except and to the extent expressly provided under the Plan or the Benefit Program. The fact that payments have

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

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 otherwise recovering such overpayment from whoever has benefited from it.

Misuse of Plan

Triad 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; Triad is not responsible for their actions. Neither the Plan Administrator nor Triad 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 Triad 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, Triad 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 Triad.

Limited Authorization of Payments

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. Authorizations of payments to a provider or direct payments to a provider are not assignments of benefits. Even though you may authorize a provider to receive a payment or reimbursement of covered services and even though a Claims Administrator may pay a provider directly for payments or reimbursements of covered services, in no event will any such authorizations, payments or reimbursements to or on behalf of a provider cause the provider to become a Plan participant or Plan beneficiary (or assignee of a participant or beneficiary) under ERISA.

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.

No Assignment of Rights and Benefits

Your rights and benefits under any benefit program under the Plan cannot be assigned, sold or transferred to any person, including your health care provider. For this purpose, your Plan rights and benefits, include, without limitation, the right to file an administrative appeal (internal and external), the right to sue following a denied administrative appeal, and any other Plan rights and benefits, whether actual or potential. Any purported assignment of rights and/or benefits under the Plan shall be void and shall not apply to the Plan. Further, a payment or reimbursement of covered services by a Claims Administrator to a health care provider (whether pursuant to an authorization or otherwise) will not waive the application of this provision. The application of this provision does not affect your right to appoint an authorized representative.

Health Care Provider Agreements not Binding on the Plan

Sometimes your healthcare provider requests that you sign various agreements and other documentation as a condition of receiving healthcare services from the provider. Any agreement, assignment or other document executed by you and a health care provider (or executed by parties that include you and a health care provider, but that do not include the Plan Administrator) are not binding on and will have no legal effect whatsoever on the Plan or any Claims Administrator. Further, a payment or reimbursement of covered services by a Claims Administrator to a health care provider (whether pursuant to an authorization or otherwise) will not waive the application of this provision.

Triad's Use of Funds

To the maximum extent permitted by applicable law, Triad shall be entitled to retain any policy dividend or refund, or portion thereof, it receives from any insurance company, administrative services organization, accountable care 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 plan assets, rebates, refunds, or demutualization awards, if any. The rest of the cost of administering the Plan is paid entirely by Triad.

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 Triad, 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 Triad contributions, or administrative fees) to reduce the level of contributions that Triad 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.

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.

HIPAA Privacy and Protected Health Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. The portion of the Plan that provides medical benefits has a responsibility under the HIPAA Privacy Regulations to provide you with a Notice of Privacy Practices. This notice sets forth the employer's rules regarding the disclosure of your information and details about a number of individual rights you have under the Privacy Regulations. If you would like a copy of the Plan's Notice, it is located on the LANL Benefits Website for retirees.

If you have a complaint about the way that your personal health information is handled by Triad or a Claims Administrator, you are encouraged to share your complaint with Triad by contacting the LANL Benefits Office at (877) 667-1806 or (505) 667-1806. Triad is committed to trying to resolve your concerns about the privacy of your personal information. Additional rights that you may have are described in the Privacy Notice.

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). This Statement of Rights includes revisions to the ERISA model to reflect the Plan's terms and rules regarding mandatory arbitration. The Benefit Programs maintained by Triad that are governed by ERISA include those described in this SPD. ERISA provides that all Plan participants have the right to:

Receive Information About Your Plan and Benefits

You can examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites) all documents governing the Plan. This includes insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

By submitting a written request to the Plan Administrator, you can obtain copies of documents governing the operation of the Plan, including insurance contracts, copies of the latest annual report (Form 5500 Series), and an updated summary plan description. (The administrator can charge you a reasonable fee for the copies.) You should receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to provide a copy of this summary annual report to each Plan participant.

Continue Group Health Plan Coverage

You can continue health care coverage (medical, dental or vision) for yourself, spouse, and/or your dependents if there is a loss of coverage under the Benefit Program as a result of a qualifying event. You and your dependents may have to pay for such coverage. For more details, review Section 9, "Continuation of Health Care Coverage," the relevant Benefit Program materials, and the COBRA notice that was mailed to your home. If you need another copy of any of these documents, please contact the COBRA Administrator located in Appendix G.

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 Triad, 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, including bringing legal action in federal court. However, this Plan reflects its requirement to submit claims for mandatory arbitration. 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 bring an action in arbitration to 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.

Under ERISA, after exhausting your appeal rights, you may file suit in federal court if you have a claim for benefits which is denied or ignored, in whole or in part, and 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. Under this Plan, such actions must be submitted instead to mandatory arbitration.

You may seek assistance from the U.S. Department of Labor, or you may be entitled to file an arbitration proceeding, or to the extent required under ERISA, to file suit in a federal court if:

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

The arbitrator or, court, to the extent applicable, 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.qov. 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.qov/ebsa.

Additional Information

Additional pertinent information is attached as follows

Appendix A: **Premium Contribution Arrangements**

Appendix B: **Surviving Family Members Welfare Benefits**

Appendix C: **Benefit Program Materials**

Appendix D: **Claim and Appeals Administration Information**

Appendix E: **Funding and Contract Administration Information**

Appendix F: **Plan Administration Information**

Appendix G: **Insurance Carrier Contact Information**

Appendix A: Premium Contribution Arrangements

The following chart indicates who pays for the premiums for each Benefit Program – you and Triad, or you alone. Total Medical and Dental Premium costs will be determined annually by Triad. Retirees will be responsible for any part of the premium cost not paid for by Triad as described herein. *Note: You must be enrolled in medical coverage under the Triad Health and Welfare Plan for Employees (formerly referred to as the LANS Welfare Benefit Plan for Employees) as of the date of your termination from LANS or Triad in order to be eligible for Retiree coverage.*

Section 1 ELIGIBILITY CATEGORIES A-D (Section 2 for Eligibility Rules)	Section 2 TRIAD CONTRIBUTION TO RETIREE WELFARE BENEFITS	
Service Credits' for Triad Contributions (if any)	Eligibility for Subsidy (Medical & Dental)	Legal/AD&D
A. Be a former employee of the University of California (UC) at Los Alamos National Laboratory (LANL) (or current or surviving family member of such former UC-LANL employee) who is receiving or is eligible to receive retiree welfare benefits from UC on May 31, 2006. ***Service Credits[4] are based on years of service with UC.***	**Eligible Retirees (A – D)** Triad contribution is determined by applying a service-based factor ("Service Credits") to the maximum Triad contribution, as follows (Sick Leave balances are included in the Service Credit Calculation for TCP1 only): • 0-4 years of Service Credit - 0% Triad contribution • 5-9 years of Service Credit and do not meet the Rule of 75 - 0% Triad contribution • 5-9 years of Service Credit and meet the Rule of 75[3] - 50% Triad contribution (TCP2 Requires >5 years of frozen UC or frozen M&O/EM/DOE Prime contract service credit, UC Transitioning TCP1 Employee's need >5 years combined UC and LANS or Triad service credit.) • 10 years of Service Credit - 50% Triad contribution • 11-20 years of Service Credit - 50% Triad contribution, plus a 5% additional increment for each full year of Service Credit[4] above 10 years, up to 100% of Triad contribution **Medicare-Eligible Retirees** Medicare eligible participants are required to enroll in Medicare Part A&B. The Plan will reimburse the Retiree's Medicare Part B premium up to a maximum of $96.40/month.	No Triad Contribution. Access Only.
B. Be a former employee of UC at LANL who terminated from UC before June 1, 2006, and who, within 120 days of termination from UC elected to receive a monthly pension from the University of California Retirement Plan (UCRP). ***Service Credits are based on years of service with UC.***		
C. Be a former employee of LANS or Triad who is a UC Transitioning Employee[1] who property elected TCP1, and who is vested with 5 years of Service Credits[4] and is eligible to receive a monthly disability benefit under the Triad Defined Benefit Eligible Disability Program (DBED) (formerly LANS Defined Benefit Eligible Disability Program) and who applies for welfare benefits within 120 days of termination from LANS or Triad. ***Service Credits[4] are based on years of service with UC frozen upon transfer to LANS on June 1, 2006, years of service at LANS from June 1, 2006 through October 31, 2018, and years of service at Triad on or after November 1, 2018.*** ***The Rule of 75[3] does not apply.***		

D. Be a former LANS employee who retires from a benefits eligible appointment at LANS between June 1, 2006 and October 31, 2018 or be a LANS or Triad employee who retires from a benefits eligible appointment at Triad on or after November 1, 2018 and who applies for Triad welfare benefits (formerly LANS welfare benefits) within 120 days of termination from Triad (formerly LANS), and who is: (Rule of 75 applies) 1. a UC Transitioning Employee[1] who properly elected TCP1 and is receiving a monthly pension from the Triad Defined Benefit Pension Plan (formerly the LANS Defined Benefit Pension Plan); or ***Service Credits[4] are based on years of service with UC frozen upon transfer to LANS on June 1, 2006, years of service at LANS from June 1, 2006 through October 31, 2018, and years of service with Triad on or after November 1, 2018.*** 2. a UC Transitioning Employee[1] who (i) properly elected TCP2 who is receiving a monthly pension from the UCRP, or (ii) properly elected TCP2 and who was not vested in the UCRP on June 1, 2006; or ***Service Credits[4] are based on years of service with UC frozen upon transfer to LANS on June 1, 2006.*** 3. A Direct Transfer Employee[2] hired by LANS between June 1, 2006 and October 31, 2018 with at least 10 years credited service for work performed on DOE Management & Operating, Environmental Management and other DOE Prime contracts, with their parent company or affiliates (including predecessor contractors). ***Service Credits are based on credited service for years of work performed on DOE Management & Operating, Environmental Management and other DOE Prime contracts with their parent company or affiliate (including predecessor contractors) frozen upon transfer to LANS or Triad. Service Credits are also based on credited years of service since June 1, 2006.***	Medicare Part B Reimbursement is not available for Access Only participants. **Special Rules** • UC Transitioning Employees[1] who properly elected TCP1 or TCP2 upon transfer to LANS, and who were hired in a career position with UC before January 1, 1990, and who apply for Triad welfare benefits (formerly LANS welfare benefits) within 120 days from their termination date, receive 100% of the Triad maximum contribution. Any break in service after January 1, 1990 of >120 days will make you ineligible for the 1990 Rule. • Retirees who, immediately before retirement, were receiving a monthly disability benefit under the Triad Defined Benefit Eligible Disability Program (formerly the LANS Defined Benefit Eligible Disability Program) continue with a 50% Triad contribution even if they have less than 10 years of service. Upon retirement, the Service Credits earned while on disability status counts toward determining the percentage of the Triad contribution toward medical and dental coverage. See 11-20+ Rules if years of service fall into this category. **Retiree Medical and Lump Sum Cash Out** If you previously elected to receive a lump sum cash out from the UCRP, your Service shall not include any years of service attributable to service you earned before June 1, 2006. However, any service you earn on or after June 1, 2006 will be included in your service credit calculation.	
Section 3 - Service Credits *Access Only*	**Section 4 – No Triad Contribution. *Access Only.***	
E. Be a (1) a LANS employee hired between June 1, 2006 and October 31, 2018, (2) a UC Transitioning Employee who elected TCP2 and who took a lump sum distribution of his/her UCRP pension benefit, or (3) a Triad employee who was hired on or after November 1, 2018, and who retires from a benefits eligible appointment on or after November 1, 2018 and who applies for Triad welfare benefits (formerly LANS welfare benefits) within 120 days of termination from Triad. ***Service credits are based on years of service with LANS between June 1, 2006 through October 31, 2018 and years of service with Triad on or after November 1, 2018.***	**Eligible Retirees (E)** Employee ("Service Credits): • 0-9 years of LANS and Triad Service Credits— Ineligible • >10 years of LANS and Triad Service Credit— Access Only • The Rule of 75 does not apply. • The Rule of 1990 does not apply. • Sick leave balances will not be included in calculation for TCP2 Years of Service.	

[1]A UC Transitioning Employee means an individual who became employed by LANS on June 1, 2006, and was employed by the University of California (UC) on May 31, 2006, and did not retire from UC.
[2]A Direct Transfer Employee means an employee of LANS who transfers to LANS directly from UC (excluding UC-LANL), Bechtel, B&W and URS (LANS Parent Companies) or directly from an Affiliate of LANS Parent Companies from June 1, 2006 through October 31, 2018. 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 applicable Service Credits equal 75 TCP2 employees must have: >5 years of frozen UC or frozen M&O/EM/DOE Prime contract service credit, UC Transitioning Employee's TCP1 need >5 years of UC service credit plus LANS or Triad service credit.

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").

In addition, to be eligible, the surviving spouse or domestic partner must also be named as a Contingent Annuitant under either the UCRP or the Triad Defined Benefit Pension Plan (formerly LANS Defined Benefit Pension Plan), as applicable and have been married (or have been in an approved domestic partner relationship) for at least one year prior to commencement of your pension benefit.

If the eligible surviving family member is not enrolled in the Medical, Dental, Vision, and/or Legal Program under this Plan on the date of death of the Deceased, the surviving family member, if named the contingent annuitant, must contact Empyrean within 31 days to suspend their eligibility under the deceased retirees account. If the contingent annuitant is still active and covered under other insurance, but at some point in the future loses that coverage, that qualifying life event would allow them to pick up the suspended coverage within 31 days of the qualifying event and to enroll in the benefit(s) in which he or she was not enrolled on the date of the retiree's 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 Triad-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 Triad-sponsored benefits.

Surviving family members receiving a benefit under the Triad Defined Benefit Survivor Income Benefit Program may also be eligible for benefits under the Plan (while such SIP benefits continue). Please contact the Plan Administrator for additional details.

Triad Contribution toward Medical and Dental Premiums for Survivors

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

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

* Exceptions to the Triad contributions set forth above: Eligible survivors of the following will receive 100% of the Triad 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; and

- A Triad employee, disabled former employee, or retiree 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[3] and whose membership in the UCRP began before January 1, 1990, without a break in service from either the UCRP or the Triad Defined Benefit Pension Plan (formerly the LANS Defined Benefit Pension Plan) of more than 120 days.

If Coverage Ends

If you were covered by Triad 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 your health coverage under COBRA.

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 G.

Appendix C: Benefit Program Materials

The certificates or booklets for each option under each Benefit Program, 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. These certificates or booklets can be accessed through the Empyrean website or by contacting the benefits department at LANL.

Medical Blue Cross Blue Shield of New Mexico
National Medicare Supplement (Retirees with Medicare A & B only)
National EPO
National PPO
Dental
Vision
Legal
Accidental Death & Dismemberment (AD&D)

You can also contact the Benefit Program provider listed in Appendix G if you would like to 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. All claims regarding eligibility must be directed in writing to the Plan Administrator and all appeals regarding eligibility claims must be directed in writing to the Benefits Appeals Committee.

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

Claims Administrator	
Medical	Blue Cross Blue Shield of New Mexico P.O Box 27630 Albuquerque, NM 87125-7630 (877) 878-5265
Dental	Delta Dental of New Mexico One Sun Plaza - Sun Avenue NE, Ste. 400 Albuquerque, NM 87109 ((877) 395-9420
Vision	Davis Vision Care Processing Unit P.O. Box 1525 Latham, NY 12110 (800) 999-5431
Legal	ARAG 400 Locust Street, Suite 480 Des Moines, IA 50309 (800) 247-4184
AD&D	MetLife (effective January 1, 2021) P.O. Box 6100 Scranton, PA 18505 (800) 638-6420, Opt. #2

Eligibility to Participate in the
Triad Health and Welfare
Plan For Retirees and any Benefit Program

Benefits Appeals Committee
c/o Plan Administrator – Triad Welfare
P.O. Box 1663, MS P280
Los Alamos, NM 87545

Appendix E: Funding and Contract Administration Information

Unless otherwise specifically indicated below, the Contract Administrator listed below has full discretionary authority to administer and interpret the Benefit Program in question and to determine eligibility for participation and for benefits under the terms of that Benefit Program. Note that COBRA is administered by the COBRA Administrator identified in Appendix G.

BENEFIT PROGRAM	TYPE OF FUNDING
Medical	
Blue Cross Blue Shield of New Mexico	self-funded
Dental	
Delta Dental of New Mexico	self-funded
Vision	
Davis Vision	self-insured
Accidental Death & Dismemberment (AD&D)	
MetLife	insured
Legal	
ARAG	insured

Appendix F: Plan Administration Information

Official Plan Name	Triad Health and Welfare Plan for Retirees (See Appendix C for a listing of Benefit Programs applicable to this SPD).
Employer/Plan Sponsor	Triad National Security, LLC P.O. Box 1663, MS P280 Los Alamos, NM 87545 (877) 667-1806 or (505) 667-1806
Employer I.D. Number (EIN)	82-3291283
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 Triad and the carriers. The carriers – not Triad – 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 Triad.
Plan Administrator	Triad National Security, LLC Benefits and Investment Committee Attn: Benefits Group Leader LANL Benefits Office P.O. Box 1663, MS P280 Los Alamos, NM 87545 (877) 667-1806 or (505) 667-1806
Claims Administrator	See Appendix D
Agent for Service of Legal Process	C T Corporation System, 206 S Coronado Ave., Espanola NM 87532-2792
Plan Year	Generally January 1 – December 31
Contribution Sources	Triad and participant contributions

Appendix G Insurance Carrier Contact Information

Empyrean	
Website	www.lanlbenefits.com
Member Services	(844) 805-0002
Aon Hewitt's Your Pension Resource (YPR)	
Website	https://ypr.aon.com/losalamos/#/
Member Services	(866) 370-7301
Blue Cross Blue Shield of New Mexico (BCBSNM)	
Group Number	HDHP (113794), PPO (N13794), EPO (N13793; PPO (N13794); CDHP (N13795)
Website	http://www.bcbsnm.corn/lanl/
Member Services	(877) 878-5265
Delta Dental of New Mexico	
Group Number	04000
Website	www.deltadentalins.com
Member Services	(877) 395-9420
Claims Address	One Sun Plaza – 100 Sun Avenue NE, Ste. 400, Albuquerque, NM 87109
Davis Vision	
Group Number	N/A
Member Services	(800) 999-5431
Claims Address	P.O. Box 1525, Latham, NY 12110
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 401(k)	
Website	https://netbenefits.fidelity.com/
Member Services	(800) 835-5095
COBRA Administrator	
Email	cobra@bcbsil.com
Member Services	(800) 541-7107
Address	P.O. Box 1180, Marion, IL 62959-7680
MetLife Voluntary AD&D Administrator	
Email	Lifeclaimsubmit@metlife.com
Member Services	(800) 638-6420 (Opt #2 – Claims Customer Service)
Address	P.O. Box 6100, Scranton, PA 18505