Sandia National Laboratories
Operated for the U.S. Department of Energy by
Sandia Corporation

Benefits Department
P.O. Box 5800
Albuquerque, NM 87185-1463

June 1, 2008

Dear CIGNA Senior Premier PPO Plan Participant:

Our records show that you are enrolled in the CIGNA Senior Premier PPO. The following are modifications and clarifications to the Summary Plan Description (SPD). These modifications and clarifications are referred to as a Summary of Material Modifications (SMM) and are intended as a summary to supplement the SPD (effective January 1, 2006) and are a part of the official plan document. It is important that you keep this summary with your SPD since this material plus the SPD comprise your complete SPD.

Modifications effective January 1, 2007:

Entire SPD		
The following should be noted: • Remove all references to after-tax premium deductions as it relates to employees		
Section 3. Enrollment and Disenrollment		
Pages:	Under Heading:	The following should be noted:
3-2 3-3	**Enrolling Class I Dependents** **Enrolling Class II Dependents**	**Delete:** If you do not provide the marriage or the birth certificate for your new dependent, your dependent will be disenrolled and will have coverage for only the first 60 calendar days beginning with the effective date of coverage. **Replace with:** You must provide a copy of your marriage certificate or the birth certificate for your new dependent within 60 calendar days of the marriage or birth. Your dependent will not be enrolled until this paperwork is received.
Section 6. Coverages and Limitations		
Pages:	Under Heading:	The following should be noted::
6-17 & 6-18	**Immunizations/ Flu Shot Services**	**Delete:** If you are unable to obtain the type of immunization required at the physician's office (e.g. malaria pills) in Albuquerque, New Mexico, you can go to Concentra, 3800 Commons NE (505) 822-9480 and receive in-network benefits. If you need to obtain different types of immunizations for personal travel where at least one of these is not available at a physician's office, you may obtain all of your immunizations at Concentra. If you are located anywhere else in the United States, contact CIGNA HealthCare at 1-800-244-6224 for assistance. **Replace with:** If you are unable to obtain the type of immunization required for personal travel at the physician's office (e.g. malaria pills), contact CIGNA Member Service at 1-800-244-6224 for assistance in acquiring in-network coverage.

Modification effective August 1, 2007:

Section 2. Eligibility		
Page:	Under Heading:	The following should be noted:
2-1	**Retirees**	**Delete:** If you were enrolled in the CIGNA In-Network or the CIGNA Premier PPO as an employee, you will be defaulted into the CIGNA Senior Premier PPO once you retire. **Replace with:** If you were enrolled in the CIGNA In-Network Plan as an employee and reside in New Mexico, you will default to the Lovelace Senior Plan when you retire. If you were enrolled in the CIGNA Premier PPO as an employee, you will default to the CIGNA Senior Premier PPO when you retire. Your next opportunity to make a health plan coverage change will be during Sandia's fall Open Enrollment.
Section 13. Continuation of Group Health Coverage		
Page:	Under Heading:	The following should be noted::
13-1	**Retiree Medical Plan Option**	**Delete:** Unless you elect to enroll in your plan of choice within 31 calendar days of your retirement date, the CIGNA Senior Premier PPO will be your Sandia-sponsored medical care plan. The Medicare-primary covered retiree and/or covered dependents will be defaulted into the CIGNA Senior Premier PPO if an election is not made. **Replace with:** Retirement is not an eligible event allowing you to change medical plan coverage. Upon retirement at age 65 or over, you will default into this Plan if you were in the CIGNA Premier PPO as an employee. If you were in the CIGNA In-Network Plan as an employee and you retire at age 65 or over, you will default into the Lovelace Senior Plan (NM residents). Your next opportunity to make a health plan coverage change will be during Sandia's fall Open Enrollment.

Modifications effective January 1, 2008:

Section 6. Coverages and Limitations		
Pages:	Under Heading:	The following should be noted:
6-9	**Dental Services**	**Delete:** Dental implants and implant-related surgery are covered in situations where: o Permanent teeth are congenitally missing (anodontia), the result of anodontia is impaired function (e.g. chewing/eating), and the implants are not done solely for cosmetic reasons o Tooth loss occurs as a result of accidental injury o Tooth loss occurs due to a medical condition such as osteoporosis or radiation of the mouth **Replace with:** Dental implants, implant related surgery, and associated crowns or prosthesis are covered in situations where: (bulleted listing remains the same)
6-9	**Dental Services**	**Delete:** Although dental implants and implant-related surgery may be covered as indicated above, any crowns or other prosthesis required as a result of the implant are not covered. These may be covered under the Sandia Dental Deluxe/Expense Plans.

		Replace with: If you receive coverage under the medical plan for crowns or other prosthesis required as a result of implants, you cannot submit any remaining portion to your Sandia dental plan for coordination of benefits.
6-16	**Prescription Drugs** (other than those dispensed by the Prescription Drug Program)	**Delete:** The Plan will cover prescription drugs under the medical plan as follows: • Enteral nutrition for diagnosis for dysphasia (difficulty swallowing) as the sole source of nutrition, or in the case of genetic disorder of Phenylketonuria (PKU), or in the cases of RH factor disorders **Replace with:** The Plan will cover enteral nutrition/nutritional supplements/prescription drugs as follows: • Enteral nutrition/nutritional supplements for diagnosis of dysphasia (difficulty swallowing), as the sole source of nutrition, in the case of RH factor disorder, in the case of Phenylketonuria (PKU) genetic disorder, or terminal cancer.

Clarifications to the SPD:

Pages:	Under Heading:	The following should be noted:
4-2	**Premium for Retiree Medical Plan Option**	**Delete:** Retirees who retired with a service or disability pension after December 31, 1994, will share in the cost of coverage in this Plan. **Replace with:** Retirees who retired with a service or disability pension after December 31, 1994, and who are receiving pension payments, will share in the cost of coverage in this Plan.
6-14	**Obesity Surgery**	**Delete:** You have documentation from a physician of a diagnosis of morbid obesity for a minimum of five years **Replace with:** You have documentation from a physician of a diagnosis of morbid obesity for a minimum of five consecutive years
11-2	**Benefits Payment**	**Add the following:** On occasion, there are outstanding benefit payment checks that have been paid by CIGNA but have not been cashed and have been stale-dated. In this case, the primary covered member must notify either CIGNA or Sandia Benefits within two calendar years from the end of the Plan year in which the service was rendered to claim funds, otherwise the monies will be forfeited.
13-1	**Retiree Medical Plan Option**	**Delete:** If you retire from Sandia with a service or a disability pension, you are eligible for continued medical coverage through Sandia under the Retiree Medical Plan Option. **Replace with:** If you retire from Sandia with a service or disability pension and you have elected to defer your pension payments, you are not eligible for continued medical coverage through the Sandia Retiree Medical Plan Option until you begin to receive pension payments. At that time, you have 31 calendar days from the issuance of your first pension payment to elect coverage. If you do not elect coverage within those 31 calendar days, your next opportunity to elect coverage will be during Sandia's fall Open Enrollment. [**Note:** If you defer pension payments, you are not eligible for Sandia's health coverage and your surviving spouse

		(and dependents) is not covered by a Sandia medical plan and will not be able to elect the Surviving Spouse Medical Plan Option.] **Add the following:** If you return to work at Sandia after your initial retirement and accrue additional pension benefits towards your pension, and subsequently retire again, your medical premium-share amount will be based on the arrangements in place at the time of your subsequent retirement.

Sincerely,

Health, Benefits and Employee Services

Sandia National Laboratories

CIGNA Senior Premier PPO

Summary Plan Description

Effective: January 1, 2006

CIGNA Senior Premier PPO

Introduction

This Summary Plan Description (SPD) summarizes the CIGNA Senior Premier Preferred Provider Organization (PPO) Plan operations, benefits, claim filing procedures, and other Plan provisions. As you read through this SPD, you'll learn more about the covered services and special programs and tools that this Plan offers to help you take better care of yourself.

The CIGNA Senior Premier PPO Plan is being offered by Sandia Laboratories to its ***Medicare primary*** retirees and other eligible ***Medicare primary*** individuals and their ***Medicare primary*** eligible dependents. This Plan allows you to see any doctor you prefer, in or outside of the Open Access Plus network.

In addition to medical services, this CIGNA Senior Premier PPO Plan also includes a Behavioral Health Program, a Disease Management Program, and a Prescription Drug Program.

As alternatives to this Plan, Sandia Laboratories offers:

- Employees and eligible dependents the UnitedHealthcare Premier PPO, UnitedHealthcare Standard PPO, CIGNA In-Network Plan, and Kaiser Health Maintenance Organization (***HMO***) (CA)
- Non-***Medicare*** retirees and other non-***Medicare*** eligible individuals the UnitedHealthcare Premier PPO, UnitedHealthcare High Deductible Health Plan, CIGNA In-Network Plan, and Kaiser ***HMO*** (CA)
- ***Medicare primary*** retirees and other ***Medicare primary*** eligible individuals the UnitedHealthcare Senior Premier PPO, CIGNA Senior Premier PPO, Presbyterian ***Medicare*** PPO (NM), Lovelace Senior Plan (NM), and Kaiser Senior Advantage Plan (CA).

These alternatives are described by their individual SPDs.

As a member in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income and Security Act (***ERISA***) of 1974. This information, as well as certain general information concerning the Plan, is included as a separate booklet called "***ERISA*** Information."

The CIGNA Senior Premier PPO Plan is a self-insured plan for eligible members of Sandia Corporation, 1515 Eubank SE, Albuquerque, NM 87123 (employer identification number 85-0097942, plan number 519). This Plan is administered on a calendar year

basis from January 1 through December 31 for accumulation of maximums, ***deductibles***, claim filing, and filing of reports to the Department of Labor. CIGNA HealthCare, the claims administrator, has assigned the group plan number **3172368**. For information concerning service of legal process, contact the Sandia Legal Division, Sandia National Laboratories, 1515 Eubank SE, Albuquerque, NM 87123.

The information contained in this SPD is provided in accordance with the requirements of the Employee Retirement Income Security Act (***ERISA***) of 1974 and the Internal Revenue Code (***IRC***).

Copies of the SPD and the administrative manual (for a fee) are available from your Sandia Corporation (Sandia) Benefits office.

The CIGNA Senior Premier PPO Plan is maintained at the discretion of Sandia and is not intended to create a contract of employment and does not change the at-will employment relationship between you and Sandia. The Sandia Board of Directors (or designated representative) reserves the right to change or amend any or all provisions of the CIGNA Senior Premier PPO Plan, and to terminate the CIGNA Senior Premier PPO Plan at any time without prior notice, subject to applicable collective bargaining agreements. If the CIGNA Senior Premier PPO Plan should be terminated or changed, it will not affect your right to any benefits to which you have already become entitled.

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Section 1. Summary of Plan Changes

This CIGNA Senior Premier PPO is being offered in conjunction with the UnitedHealthcare Senior Premier PPO that was part of the Sandia Top PPO Plan administered by United of Omaha.

This CIGNA Senior Premier PPO and the UnitedHealthcare Senior Premier PPO offer the same general benefits except for the prescription drug program. The prescription drug program is part of the CIGNA Senior Premier PPO; whereas, the prescription drug program under the UnitedHealthcare Senior Premier PPO is a carve out plan provided by PharmaCare. Other differences between the UnitedHealthcare Senior Premier PPO and this CIGNA Senior Premier PPO include:

- Network of providers and facilities
- Disease management programs
- Case management providers
- Website tools and services
- Nurse advice line
- Member service
- Account management team.

Review the UnitedHealthcare Senior Premier PPO Summary Plan Description, Section 1. Summary of Plan Changes for specific plan changes from the Top PPO Plan.

The specific changes between the Sandia Top PPO Plan and the UnitedHealthcare Senior Premier PPO that apply to this CIGNA Senior Premier PPO are:

- ***Coinsurance*** (20%) replaced ***copay*** (in-network) for medical services
- The out-of-network $25 office visit ***copay*** changed to 20% of ***usual and customary charges***
- Certain in-network preventive care is covered at 100% of ***eligible expenses***
- The annual calendar year ***deductible*** is $1,000 per person for in- and out-of-network combined services
- The annual calendar year ***out-of-pocket (OOP) maximum*** increased from $250 per person to $1,000 per person
- Prescription drug ***copays*** increased at retail network pharmacies as follows:
    - Generic increased from $9 maximum to $12 maximum
    - Preferred brand-name increased from $17 minimum to $25 minimum and from $32 maximum to $40 maximum

- Nonpreferred brand-name increased from $30 minimum to $40 minimum and from $50 maximum to $60 maximum

- Prescription drug ***copays*** increased at mail order as follows:
  - Generic increased from $13 to $18
  - Preferred brand-name increased from $43 to $65
  - Nonpreferred brand-name increased from $75 to $100
- The provision allowing for late enrollment (beyond the 31 calendar day period) for new dependents of the primary covered member has been dropped
- Member must provide a copy of the birth or marriage certificate for newly enrolled dependents within 60 calendar days of the birth or marriage; otherwise, the dependent will be disenrolled from the Plan
- Primary covered member who have dependents covered under the Plan who are not tax dependents as identified under ***IRC*** Section 152 for purposes of health care coverage may need to have imputed income on the applicable premium.
- Premium-sharing decreased for ***Medicare primary member***
- A Disease Management Program has been added. This is a voluntary program to help members manage chronic conditions for asthma, diabetes, heart disease, low back pain, and chronic obstructive pulmonary disease.

Highlights

This CIGNA Senior Premier PPO is administered by CIGNA HealthCare. This Plan provides CIGNA HealthCare's Open Access Plus network, which means that members are free to see either an in-network (CIGNA contracted) or out-of-network (non-CIGNA contracted) provider or facility.

- This Plan gives members referral-free access to CIGNA HealthCare's nationwide network of providers. This means that you do not need to get a referral from a ***primary care physician*** to see a ***specialist***.
- Certain in-network preventive care is covered at 100%.
- Both in- and out-of-network coverage is available, although members generally receive a greater benefit when they choose an in-network provider.
- Coverage is available worldwide for ***emergency*** and ***urgent care***.
- ***Coinsurance*** indicated as a percentage is the amount the patient pays and is based on either the ***negotiated fees*** (in network) or ***usual and customary charges*** (out of network). The ***coinsurance*** amounts that you pay for services or supplies apply towards the individual, ***out-of-pocket maximum*** of $1,000.
- Prescription drug ***copays*** and out-of-network behavioral health benefits do not apply to the ***out-of-pocket maximum***.

- After the covered member has reached the annual $1,000 ***out-of-pocket maximum*** (not applicable to ***outpatient*** prescription drugs or out-of-network behavioral health benefits), benefits will be paid up to 100% after coordination with ***Medicare*** Parts A and B or any other insurance coverage you may have.
- Infertility benefits and the Employee Assistance Program benefits are not available to ***Medicare primary members*** under this Plan.
- Members have a lifetime maximum (with the exception of ***outpatient*** prescription drugs) of $150,000.
- The first $3,500 paid out annually does not apply to the lifetime maximum. If you reach the $150,000, the Plan will only pay $3,500 per year in benefits.
- The prescription drug coverage under this plan is not available to you if you have primary prescription drug coverage under another group health care plan.
- You are not required to enroll in ***Medicare*** Part D if you participate in this Plan.
- If you enroll in ***Medicare*** Part D while enrolled in this Plan, you will not be eligible for prescription drug coverage under this Plan. You must notify Sandia Benefits of your enrollment in ***Medicare*** Part D.
- The prescription drug program is administered through CIGNA HealthCare.
- The prescription drug program is a three-tiered plan that includes generic, preferred-brand, and non-preferred brand drugs that are available through either retail or mail order.
- Prescription drugs purchased through retail are at a ***coinsurance*** amount with minimum and maximum ***copay*** amounts for a 30-day supply. If the actual cost of the prescription is less than the minimum ***copay*** amount, then you will pay only the actual cost of the drug.
- Prescription drugs purchased through mail order are at a flat ***copay*** amount for a 90-day supply. The Mail-Order Drug Program is through Tel-Drug. Ask your doctor about getting a mail-order prescription for maintenance drugs.

Guidelines

It is important that members eligible for ***Medicare primary*** coverage enroll in ***Medicare*** Parts A and B as soon as possible. Coverage under the CIGNA Senior Premier PPO will be in coordination with ***Medicare*** coverage. Claims will be paid as though you are enrolled in both ***Medicare*** Parts A and B.

Member Resources

CIGNA HealthCare offers the following member resources to aid you in managing your care and achieving better health.

- Members may obtain a list of network providers, order identification (***ID***) cards, view claim history, and view Explanations of Benefits (***EOBs***) by registering at www.mycigna.com to view their personalized information.
- The Disease Management Program, a voluntary program to help members manage chronic conditions for asthma, diabetes, heart disease, low-back pain, and chronic obstructive pulmonary disease, has been added. Members receive personalized guidance and support from an experienced registered nurse as well as receive reminders about important screenings and exams.
- A health information nurse advice line is available 24 hours a day, seven days a week at 1-800-564-9286.

Section 2. Eligibility

This section outlines who is eligible to enroll in this Plan. This section also provides information concerning your dependents who may qualify for dependent coverage under this Plan. The end of this Section provides information on ***Qualified Medical Child Support Orders*** (***QMCSO***) and your appeal rights concerning eligibility status determinations.

If you or your eligible dependents are enrolled in this Plan, ***Medicare*** is considered your primary coverage and benefits are coordinated with ***Medicare*** as though you have both ***Medicare*** Parts A and B.

> **Note:** Under this Plan, covered members cannot be covered as both a primary covered member and a dependent, or as a dependent of more than one ***primary covered member***.

The following ***Medicare primary*** groups are eligible to enroll in this Plan:

- Retirees
- Long-term disability (LTD) terminees
- Surviving spouses
- Covered member who elects temporary coverage under ***COBRA***
- Dependents of the primary covered member in a Sandia-sponsored medical plan.

IMPORTANT

*If a covered member, who is eligible for **Medicare primary** coverage, is provided primary coverage under this or any other Sandia-sponsored medical plan, the primary covered member will be responsible for reimbursing Sandia for any ineligible benefits.*

Refer to the ***Medicare*** booklet "Enrolling in ***Medicare***" for information about enrolling in ***Medicare*** Parts A and B. You can access the booklet from ***Medicare*** at www.medicare.gov or 1-800-633-4227, or at your local Social Security office.

Retirees

Retirees age 65 or older are considered ***Medicare primary*** and are eligible for secondary coverage by this Plan. If you were enrolled in the CIGNA In-Network or the CIGNA Premier PPO as an employee, you will be defaulted into the CIGNA Senior Premier PPO once you retire.

Upon becoming eligible for ***Medicare primary*** coverage (reach age 65), you have the option of enrolling in either the CIGNA Senior Premier PPO Plan or the Lovelace Senior

Plan (certain NM counties only). You also have the option of dropping coverage under any Sandia-sponsored medical plan. You must notify Sandia Benefits, in writing, within 31 calendar days of becoming eligible for ***Medicare primary*** coverage, of any change you decide to make.

If you do not notify Sandia Benefits within 31 calendar days of becoming eligible for ***Medicare primary*** coverage, then your coverage under a Sandia-sponsored medical plan will be defaulted to the CIGNA Senior Premier PPO Plan.

Your next opportunity to select a different plan will be during the Open Enrollment period Sandia holds each fall, and coverage will be effective January 1 of the following calendar year.

Note: Retirees who will become ***Medicare primary*** due to age will be sent a courtesy letter by Sandia Benefits informing them of the opportunity to enroll in ***Medicare*** and of the medical plan options available. If you do not receive this letter, you are still responsible for enrolling in ***Medicare*** Parts A and B to receive full medical benefits.

Long-Term Disability Terminees

If you have been receiving Social Security disability benefits for 24 months or longer and have terminated from Sandia, you are eligible for ***Medicare primary*** coverage and are eligible for secondary coverage under this Plan.

Upon becoming eligible for ***Medicare primary*** coverage, you have the option of enrolling in the CIGNA Senior Premier PPO Plan or the Lovelace Senior Plan (certain NM counties only). You also have the option of dropping coverage under any Sandia-sponsored medical plan. You must notify Sandia Benefits, in writing, within 31 calendar days of becoming eligible for ***Medicare primary*** coverage of any change you decide to make. If you do not notify Sandia Benefits within 31 calendar days of becoming eligible for ***Medicare primary*** coverage, your coverage under a Sandia-sponsored medical plan will be defaulted to the CIGNA Senior Premier PPO.

Your next opportunity to select a different plan will be during the Open Enrollment period Sandia holds each fall, and coverage will be effective January 1 of the following calendar year.

Important

*If you enroll in this plan, **Medicare** is considered your primary coverage, and benefits are coordinated with **Medicare** as though you have both **Medicare** Parts A and B. In order to obtain the full benefits under this Plan, you must enroll in **Medicare** Parts A and B.*

Other Eligible Persons

Other ***Medicare primary*** persons who are also eligible to enroll in this Plan are a:

- Surviving spouse of a regular Sandia employee or retiree
- Covered member who elects and pays for temporary coverage (COBRA) and pays the appropriate premium when required.

Eligible Dependents

This Plan provides coverage for Class I and Class II dependents who are ***Medicare primary***. Benefit provisions of this Plan generally apply to both Class I and Class II dependents except that Class II dependents are not eligible for coverage of ***substance abuse*** services under the behavioral health benefits.

Class I Dependent Coverage

Class I dependents, of a retiree, ***LTD terminee***, or a survivor, who are eligible for ***Medicare primary*** coverage will be enrolled in this Plan if the retiree, ***LTD terminee***, or survivor is enrolled in the CIGNA Premier PPO, CIGNA In-Network Plan or the CIGNA Senior Premier PPO.

Class I dependents, of employees, who are eligible for ***Medicare primary*** coverage (whether due to age or disability) are eligible for coverage under the employee's plan.

Note: Domestic partners of employees who attain age 65 are considered as having ***Medicare*** as their primary coverage and will be enrolled in this Plan.

Class II Dependent Coverage

Class II dependents of the retiree, ***LTD terminee***, or survivor who are eligible for ***Medicare primary*** coverage will be enrolled in this Plan if the retiree, ***LTD terminee***, or survivor is enrolled in the CIGNA Premier PPO or CIGNA In-Network Plan or the CIGNA Senior Premier PPO.

Class II dependents, of employees, who are eligible for ***Medicare primary*** coverage (due to age) will be enrolled in this Plan if the employee is enrolled in the CIGNA Premier PPO or the CIGNA In-Network Plan.

Class II dependents, of employees, who are eligible for ***Medicare primary*** coverage (due to disability only) are eligible for coverage under the employee's plan.

Provision for Dependents with End-Stage Renal Disease

The primary covered member's plan may continue as his/her dependent's primary coverage for the first 33 months (from the time dialysis is started), which includes the 30-month coordination period with ***Medicare*** as secondary payer. After the 30-month coordination period, ***Medicare*** will become the dependent's primary coverage.

IMPORTANT

*Covered members who become eligible for **Medicare primary** coverage should enroll in **Medicare** Parts A and B. Once a covered member becomes eligible for **Medicare primary** coverage, Sandia will pay benefits **only** as a secondary payer for coverage under this Plan, regardless of whether the member enrolls in **Medicare** Parts A and B.*

All ***Medicare primary*** family members must be enrolled in the same plan, and all non-***Medicare primary*** family members must be enrolled in the same plan.

Refer to the ***Medicare*** booklet *Medicare & You* for more information. You can access the booklet from ***Medicare*** at www.medicare.gov or 1-800-633-4227, or at your local Social Security office.

IMPORTANT

*As an employer, Sandia is obligated to accurately withhold income and employment taxes. If your Plan dependent does not qualify as a tax dependent under **IRC** Section 152 for purposes of health care coverage for the entire year, you may be subject to imputed income. Refer to Section 4, Group Health Plan Premiums, for more information.*

Class I and Class II Dependents Defined

Eligible dependents include Class I and Class II dependents as defined below who are dependents of a primary covered member and any child of a primary covered member who is recognized as an ***alternate recipient*** as a result of a ***QMCSO***.

Class I Dependents

If you are the primary covered member under this Plan, your Class I dependents who are eligible for enrollment in this Plan include your ***Medicare primary***:

- Spouse, not legally separated or divorced from you

  Note: An annulment also makes the spouse ineligible for coverage.

- Unmarried child under age 19, including legally adopted ***children***

- Unmarried child age 19 and over, but under age 24, who is ***financially dependent*** on you
- Unmarried child of any age who:
  - Is permanently and ***totally disabled*** and is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months
  - Lives with you, in an institution, or in a home that you provide, and
  - Is financially dependent on you
- Unmarried child who is recognized as an ***alternate recipient*** in a ***QMCSO***.

Class II Dependents

If you are the primary covered member under this Plan, your Class II dependents who are eligible for coverage under this Plan include your ***Medicare primary***:

- Unmarried child or stepchild who is not eligible as a Class I dependent
- Unmarried grandchild
- Unmarried brother or sister
- Parent, stepparent, or grandparent (of you or your spouse)

Note: Class II dependent's premium share is a separate premium share that differs according to whether the Class II dependent is eligible for ***Medicare***.

Class II dependents may qualify for this Plan if he and/or she:

- Is financially dependent on you
- Has a total income, from all sources, of less than $15,000 per calendar year other than the support you provide
- Has lived in your home or one provided by you in the United States for the most recent six months.

Note: If you have a Class II dependent who is studying at a school outside of the United States and is expected to return home to the United States after the completion of those studies, he/she will be considered as residing in your home in the United States (provided that you are paying for his/her living expenses while he/she is abroad and he/she meets the other qualifying criteria). The Class II dependent must have lived with you or in a home you provided for the previous six months before leaving to study aboard.

Qualified Medical Child Support Order

Generally, your Plan benefits may not be assigned or alienated. However, an exception applies in the case of any child of a covered member (as defined by ***ERISA***) who is recognized as an ***alternate recipient*** in a ***QMCSO***. A ***QMCSO*** is an order issued by a court or administrative agency pursuant to applicable state domestic relation laws that assigns a child the right of a participant or beneficiary to receive benefits under an employer-provided health plan, regardless of with whom the child resides. This Plan will comply with the terms of a ***QMCSO***.

An "***alternate recipient***" is any child of a primary covered member (including a child adopted by or placed for adoption with a primary covered member) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such primary covered member.

Federal law provides that a medical child support order must meet certain form and content requirements in order to be a ***QMCSO***. When a medical child support order is received, each affected primary covered member and each child (or the child's representative) covered by the order will be given notice of the receipt of the order. Coverage under the Plan pursuant to a medical child support order will not become effective until the plan administrator determines that the order is a ***QMCSO***. ***QMCSO*** will be reviewed by Sandia's Legal Organization within 40 business days. If you have any questions or you wish to obtain a copy of the procedures governing ***QMCSO*** determination, contact Sandia Health, Benefits, and Employee Services (***HBES***) at (505) 844-4237. You have a right to obtain a copy of the procedures governing ***QMCSO*** at no charge.

Eligibility Appeal Procedures

If this Plan denies your claim or your dependent's claim **because of eligibility,** you may contact the Sandia ***HBES*** at (505) 844-4237 to request a review of eligibility status. A written notification will be sent to you within three business days of your request, informing you of your eligibility status.

You may appeal any eligibility status determination by writing to the Sandia Employee Benefits Committee (***EBC***), Attn: Benefits Dept., MS 1022, Sandia National Laboratories, P. O. Box 5800, Albuquerque, NM 87185.

You must appeal to the ***EBC*** within 180 days of the date of the letter informing you of the eligibility status determination. The ***EBC*** has the exclusive right to interpret eligibility. The secretary of the ***EBC*** has the authority to make the final determination for ***urgent care*** appeals. The determination of the ***EBC*** or its secretary is conclusive and binding.

You must exhaust the appeal process before you seek any other legal recourse.

Plan dependent eligibility based on incapacitation is determined by CIGNA HealthCare. Contact the Sandia ***HBES*** at (505) 844-4237 for information on how to apply for dependent incapacitation status.

Note: If you do not enroll a dependent because the dependent has other medical coverage and your dependent involuntarily loses eligibility for that coverage, you may be able to enroll the dependent in your medical plan provided that you request enrollment within 31 calendar days after the other coverage ends.

Section 3. Enrollment and Disenrollment

This section outlines the enrollment procedures for retirees, survivors, and ***long-term disability terminees*** as well as how to enroll and disenroll dependents, and the consequences of not disenrolling ineligible dependents in a timely manner. It also provides information on your enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the option to waive or drop coverage. For the mid-year election change events that may allow you to make a mid-year election change, see the ***Pre-Tax Premium Plan*** booklet.

Eligible members may elect to enroll in this Plan once a year during the Open Enrollment period held each fall by Sandia and coverage will be effective January 1 of the following calendar year.

To enroll in this Plan (outside the Open Enrollment period):

- Complete the medical enrollment form (SF 4400-MED). Keep a copy as proof of coverage until you receive your ***ID*** card(s) from CIGNA Healthcare.

  All the dependent information requested on the medical enrollment form (SF 4400-MED) must be provided, including:

  - Dependent's complete name and relationship to you
  - Social Security number (not applicable to newborns)
  - Date of birth or gender

- Mail all the enrollment and disenrollment forms including supporting documentation described in this section to:

  Sandia Benefits, Mail Stop (MS) 1022
  Attn: HBES Center
  Sandia National Laboratories
  P. O. Box 5800
  Albuquerque, NM 87185

  Mail your enrollment information in plenty of time to be received within the 31 calendar day requirement for enrollment.

Note: Procedures for enrolling in the ***Medicare*** Parts A and B are available from ***Medicare's*** website at www.medicare.gov. You may also call the Social Security Administration at 1-800-772-1213 for assistance.

All ***Medicare primary*** family members must be enrolled in the same plan and all non-***Medicare primary*** family members must be enrolled in the same plan. Refer to the following table for the possible Plan combinations.

IMPORTANT

If a covered member who is eligible for ***Medicare primary*** *coverage is provided primary coverage under this or any other* Sandia-sponsored medical plan*, the primary covered member will be responsible for reimbursing Sandia for any ineligible benefits.*

Enrolling Dependents

Enrolling Class I Dependents

All Class I dependents whom you elect to have covered under this Plan must be enrolled within 31 calendar days of their ***qualifying event***, such as when they are newly eligible (e.g., marriage).

If you miss the 31 calendar day period, the next opportunity for you to enroll your eligible Class I dependents will be during the Open Enrollment period Sandia holds in the fall with coverage effective January 1 of the following year.

Effective date of coverage for your Class I dependents, enrolled within 31 calendar days of their *qualifying event*, is as follows:

Dependent Due to	Effective Date of Coverage
Marriage	Later of the date of the eligible event or the date Benefits receives completed paperwork
Legal Guardianship	Later of the date of the eligible event or the date Benefits receives completed paperwork
Birth	Retroactive coverage to date of event
Adoption	Retroactive coverage to date of event
Placement for Adoption	Retroactive coverage to date of event

IMPORTANT

The marriage or birth certificate is required within 60 calendar days of the ***qualifying event*** *(marriage or birth) to verify eligibility to enroll your new dependent.*

If you do not provide the marriage or the birth certificate for your new dependent, your dependent will be disenrolled and will have coverage for only the first 60 calendar days beginning with the effective date of coverage. Submit documentation to Sandia ***HBES***.

Coverage for an adopted child begins when the placement agreement and/or adoption papers are final. You must submit adoption papers to Sandia ***HBES***. Medical expenses of the child before adoption, including the birth mother's prenatal, postnatal, and delivery charges, are not covered.

All dependent information requested on the medical enrollment form (SF 4400-MED) must be provided including:

- Dependent's complete name and relationship to you
- Social Security number (not applicable to newborns)
- Date of birth and gender

Note: Contact Sandia ***HBES*** at (505) 844-4237 for assistance.

Enrolling Class II Dependents

All Class II dependents whom you elect to have covered under this Plan **must** be enrolled within 31 calendar days of their ***qualifying event*** such as when they are newly eligible (financial dependence, etc.).

If you miss the 31 calendar day period, the next opportunity for you to enroll your eligible Class II dependents will be during the Open Enrollment period Sandia holds in the fall with coverage effective January 1 of the following calendar year.

Effective date of coverage for your Class II dependents, enrolled within 31 calendar days of their *qualifying event*, is as follows:

Class II Dependent	Effective Date of Coverage
Unmarried child or stepchild	Later of the date of the eligible event or the date Benefits receives completed paperwork
Unmarried grandchild	Later of the date of the eligible event or the date Benefits receives completed paperwork
Unmarried brother or sister	Later of the date of the eligible event or the date Benefits receives completed paperwork
Your or your spouse's parent, step-parent, or grandparent.	Later of the date of the eligible event or the date Benefits receives completed paperwork

IMPORTANT

*A marriage or birth certificate is required within 60 calendar days of the **qualifying event** (marriage or birth) to verify eligibility to enroll your new dependent.*

If you do not provide the marriage or the birth certificate for your new dependent, your dependent will be disenrolled and will have coverage for only the first 60 calendar days beginning with the effective date of coverage. Submit documentation to Sandia ***HBES***.

Coverage for an adopted child begins when the placement agreement and/or adoption papers are final. You must submit adoption papers to Sandia ***HBES***. Medical expenses of

the child before adoption, including the birth mother's prenatal, postnatal, and delivery charges, are not covered.

All dependent information requested on the medical enrollment form, Class II Dependent Affidavit (SF 4400-CTD), **must** be provided including:

- Dependent's complete name and relationship to you
- Social Security number (not applicable to newborns)
- Date of birth and gender

You will be required every December to complete the Class II Dependent Affidavit (SF 4400-CTD) to continue coverage for your Class II dependent(s) for the next calendar year. This form **must** be received by December 31 every year to continue coverage for the next calendar year. Mail the Class II affidavit to Sandia ***HBES***.

Note: Contact Sandia ***HBES*** at (505) 844-4237 for assistance.

Disenrolling Dependents

If your dependents do not meet the dependent eligibility criteria as required by this Plan, they do not qualify for coverage under this Plan**,** and you must disenroll them.

Note: Contact Sandia ***HBES*** at (505) 844-4237 for assistance.

All ineligible dependents must be disenrolled within 31 calendar days of the event that has made your dependent no longer eligible for this Plan. Plan coverage ends at the end of the month in which the dependent became ineligible.

Events Causing Your Dependent to Become Ineligible

Your dependent becomes ineligible and you must disenroll the dependent when one or more of the following events occur:

Class I

- Divorce or annulment
- Legal separation
- ***Child*** marries
- ***Child*** is no longer ***financially dependent***
- ***Child*** no longer meets the age criteria
- Incapacitated ***child*** no longer meets incapacitation criteria

- ***Child*** no longer meets the Class I criteria
- ***Child*** no longer covered under ***QMCSO***

Class II

- ***Child***, stepchild, grandchild, brother, or sister marries
- ***Child***, stepchild, grandchild, brother, sister, parent, stepparent, or grandparent no longer meet Class II eligibility requirements criteria

How to Disenroll Dependents

- Complete the dependent disenrollment form (SF 4400 DIS)

> **Note:** If you are disenrolling a Class II dependent, you must also complete the Premium Deduction Cancellation form (SF 4400-PDC) for Class II dependents.

- Retain a copy for your files
- Mail the original to Sandia ***HBES*** within the 31 calendar day criteria.

Forms are available on Sandia's website (www.sandia.gov) under Corporate Forms or by calling Sandia ***HBES*** at (505) 844-4237.

Important

If you are disenrolling a dependent due to a legal separation, an annulment, or a divorce, you must provide a copy of the first page of the legal document.

Sandia abides by a federal law known as the Consolidated Omnibus Budget Reconciliation Act (***COBRA***) of 1985 in which temporary continued coverage is provided to dependents who would otherwise lose group coverage due to specified events. Refer to Section 13, Continuation of Group Health Coverage, for more information.

> **Note:** Contact the Sandia ***HBES*** at (505) 844-4237 for ***COBRA*** information.

Consequence of Not Disenrollng Ineligible Dependents

You **must** notify Benefits within 31 calendar days of the date that your dependent no longer meets the eligibility criteria for this Plan.

If you do not disenroll any ineligible dependents, then Sandia may:

- Take action that results in permanent loss of health plan coverage for you and your dependents for fraudulent use of the Plan

- Report the incident to the Office of the Inspector General.

If you do not disenroll any ineligible dependents, then Sandia will:

- Retroactively terminate dependent coverage, effective the end of the month in which the dependent became ineligible
- Refund any applicable premium paid by you during the ineligible period
- Hold the primary covered member personally liable to refund to Sandia all health care plan claims rendered during the ineligible period
- Terminate any rights to temporary, continued health care coverage under ***COBRA***.

Waiving or Dropping Coverage in Sandia-Sponsored Medical Plans

IMPORTANT

If you are a surviving spouse and you waive or drop coverage, you can never reenroll in a Sandia-sponsored medical plan.

You have the option to waive or drop coverage for yourself and your dependents. You can waive coverage at any time during the year including during the annual Open Enrollment period Sandia holds each fall.

Coverage for any eligible dependent is based on your coverage as the primary covered member; therefore, if you waive or drop coverage for yourself, you are also waiving or dropping coverage for all of your covered and/or eligible dependents. Coverage will end on the last day of the month in which you drop or waive coverage.

The next opportunity for you to reinstate your coverage under this Plan will be during the annual Open Enrollment period Sandia holds each fall, with coverage becoming effective January 1 of the following year. You and/or your eligible dependents may also be eligible to reenroll based on a qualified mid-year election change event. Refer to the ***Pre-Tax Premium Plan*** booklet for more information.

How to Waive or Drop Coverage

- Complete the waiver of medical coverage form (SF 4811-WMC)
- Retain a copy for your files
- Mail the original, early enough to meet the 31-calendar day criteria or the end of the Open Enrollment period, to Sandia ***HBES***

Forms are available on Sandia's website (www.sandia.gov) under Corporate Forms or by calling Sandia ***HBES*** at (505) 844-4237.

HIPAA Rights and Protection

The Health Insurance Portability and Accountability Act (***HIPAA***) provides rights and protections for participants and beneficiaries in group health plans. Under ***HIPAA***, if you waive or drop coverage for yourself and your covered dependents because of other health insurance coverage, and you and/or your covered dependents involuntarily lose eligibility for that coverage, you may be able to enroll yourself and your eligible dependents during the plan year, provided that you request enrollment and notify Benefits within 31 calendar days of loss of your coverage.

These events include:

- **Loss of eligibility under another plan.** An eligible employee or retiree (and/or his/her dependents) who declined coverage when initially eligible because of having other medical coverage, and who later loses the other coverage, may apply for coverage for himself/herself and eligible dependents within 31 calendar days of the loss of coverage.
- ***COBRA* is exhausted after coverage under another plan.** An eligible employee or retiree (and/or his/her dependents) who has exhausted coverage under another plan outside Sandia may apply for coverage for himself/herself and eligible dependents within 31 calendar days of this event.
- **Employer contributions to other coverage ends.** An eligible employee or retiree (and/or his/her dependents) for whom employer contributions to the other plan in which he/she is enrolled have ended may apply for coverage for himself/herself and eligible dependents within 31 calendar days of the date the other coverage ends.
- **Exhausting a lifetime limit under another plan.** An eligible employee or retiree (and/or his/her dependents) who has exhausted all coverage under another plan due to plan reimbursements meeting a lifetime limit under the plan may apply for coverage for himself/herself and eligible dependents within 31 calendar days of the date coverage is denied under the other plan due to the lifetime limit.

In addition, if you acquire a new eligible dependent as a result of marriage, birth, adoption, placement for adoption, or obtaining legal guardianship, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment and notify Benefits within 31 calendar days of the effective date following the event.

IMPORTANT

If you voluntarily terminate coverage for yourself or your dependents while still employed with Sandia, you are not eligible for any ***COBRA*** *continuation.*

Mid-Year Election Change Events

Mid-year election change events (exceptions include moving into or out of the service area or as described in Section 13, Continuation of Group Health Coverage) do not allow you to change from one medical plan to another medical plan sponsored by Sandia. Changes in medical plan elections are allowed only during the annual Open Enrollment period held each fall by Sandia.

Certain qualifying events may permit a mid-year election change to your medical care coverage such as the enrollment of a newly eligible dependent or the disenrollment of a dependent child who marries and no longer eligible for coverage under your plan. These changes are allowed at times other than during Open Enrollment. Refer to the ***Pre-Tax Premium Plan*** booklet for more information.

Note: Notify Sandia Benefits, in writing, within 31 calendar days of the ***qualifying event*** for a mid-year election change.

Section 4. Group Health Plan Premiums

This section outlines how premiums are charged according to type of retirees and other qualifying individuals that are eligible for coverage under a Sandia-sponsored health plan.

Benefits paid under a group health plan for your covered dependents who would not qualify as a tax dependent under the Internal Revenue Code (***IRC***) for purposes of health care coverage causes the primary covered member to receive additional compensation as taxable wages. The primary covered member is required to declare as taxable income the value of the coverage for the non-eligible dependent. Imputed income is not a pay increase. It is the value of Sandia's contributions for health coverage for dependents who are not your tax dependents. The imputed income will be added to your gross income, and may be subject to FICA (Social Security and ***Medicare***) and income taxes. This amount will be reported on your annual W-2 form or other appropriate reporting tax form.

The definition of tax dependent is set forth in the ***IRC***. If you have questions about whether your covered dependents are your tax dependents for purposes of health care coverage, consult with the ***IRC*** or your tax advisor.

If you determine that one or more of your covered dependents do not meet the definition of tax dependent as set forth in the ***IRC*** for purposes of health care coverage, contact Sandia ***HBES*** at (505) 844-4237 to obtain a form to complete so that your dependent(s) can be reflected correctly in the database. Refer to the ***Pre-Tax Premium Plan*** booklet for more information. In addition, in some instances you will also have imputed income for those premiums in the calendar year attributable to the dependent prior to the event that led to his/her ineligibility as your tax dependent and you need to notify Sandia ***HBES***.

IMPORTANT

*The primary covered member is responsible for determining whether his/her covered dependents meet the Sandia-sponsored health plan eligibility requirements and the tax dependent rules of the **IRC**. Should the **IRS** audit your tax return and determine you have obtained tax benefits for which you are ineligible, you will be responsible for any overdue taxes, interest, and penalties.*

Contact the Sandia ***HBES*** at (505) 844-4237 for assistance in disenrolling your dependents who do not qualify as your tax dependents under ***IRC*** Section 152 for purposes of health care coverage and/or in determining any taxable income.

Monthly Premium Payment for Coverage

Sandia requires a monthly premium payment for coverage of eligible individuals under this plan.

The monthly premium share amount will be deducted from:

- Employee's biweekly paycheck in two equal installments each month or
- Retiree's monthly pension check.

Other eligible covered persons pay Sandia by:

- Direct payment to Sandia
- ***COBRA*** monthly payment plus two percent administrative fee.

Premium for Retiree Medical Plan Option

The premiums for continued medical care coverage under this Plan are provided during the Open Enrollment period Sandia holds each fall. Retirees may also contact the Sandia ***HBES*** at (505) 844-4237 for premium rates.

Sandia pays the full amount of coverage for you and your covered dependents during retirement if you retired with a service pension as follows:

- Between August 8, 1977, and January 1, 1988, at age 64 or older, with at least **10** years of service as of age **65** or
- Before January 1, 1988, with at least **15** years of service or
- Between January 1, 1988, and December 31, 1994, with a service or disability pension

Retirees who retired with a service or disability pension after December 31, 1994, will share in the cost of coverage in this Plan. The current cost-sharing is as follows:

- Retirees who retired after December 31, 1994, and before January 1, 2003, will pay 10 percent of the full experienced-rated premium.
- Retirees who retired after December 31, 2002, will pay a percentage of the full experienced-rated premium based on their term of employment as follows:
    - 30+ years − 10 percent
    - 25 to 29 years − 15 percent
    - 20 to 24 years − 25 percent
    - 15 to 19 years − 35 percent
    - 10 to 14 years − 45 percent.

Retirees who do not meet the above conditions may continue coverage under a Sandia-sponsored medical plan by paying the full cost of coverage under ***COBRA***.

Dual Sandians Premium

If you are a Sandia retiree married to another Sandia retiree or to a Sandia employee, you are considered a ***dual Sandian***. You, as a ***dual Sandian***, may elect to cover yourself as (1) an individual or (2) a dependent of your Sandia spouse or (3) the primary covered employee or retiree with your Sandia spouse as a dependent. If you as the retiree are the primary covered member, cost-sharing of monthly contributions will be based on your retiree status. If you and your Sandia spouse elect to be covered separately, any eligible dependents may be covered under either spouse (i.e., some dependents may be enrolled under one spouse while other dependents may be enrolled under the other spouse). No dependents may be covered under both Sandians simultaneously.

Note: Employees, retirees, or eligible dependents cannot be covered as both a primary covered member and as a dependent, or as a dependent of more than one primary covered member.

Employees, retirees, or other qualifying individuals who are covered in any other Sandia-sponsored medical plans are not eligible to participate in this Plan. You have the option to change your Sandia-sponsored medical plan choice once a year during the Open Enrollment period Sandia holds each fall.

Premium for Long-Term Disability (LTD) Terminee Medical Plan Option

The premiums for continued medical coverage for ***LTD terminees*** under this Plan are provided during the Open Enrollment period Sandia holds each fall. You may also contact the Sandia ***HBES*** at (505) 844-4237 for premium rates.

If you became a ***LTD terminee*** before January 1, 2003, you pay 10 percent of the full experienced-rated premium for you and your covered dependents.

If you became a ***LTD terminee*** after December 31, 2002, you pay 35 percent of the full experienced-rated premium for you and your covered dependents.

Premium for Surviving Spouse Medical Plan Option

As a survivor of a regular Sandia employee or retiree, you are eligible for continuation of coverage under the Surviving Spouse Medical Plan Option by paying the applicable monthly premium.

Note: If you are a surviving spouse and you waive or drop coverage, you can never reenroll in a Sandia-sponsored medical plan.

The survivor premium payments for the first six months will be at the rate the employee or retiree was paying for coverage at the time of death. After the initial six months, the survivor (and any dependents enrolled at the time of death) may continue coverage by paying:

- 50% of the full experienced-rated premium if you are a survivor of a retiree or a regular employee with a term of employment of 15 years or more
- 100% of the full experienced-rated premium if you are a survivor of a regular employee with a term of employment of less than 15 years.

Your decision for continuation of coverage under the Surviving Spouse Medical Plan Option must be made prior to the expiration of the initial six-month coverage.

The applicable survivor rate will depend on the medical care plan under which you are covered and whether coverage is for single coverage or family coverage.

Coverage under the Sandia-sponsored medical plan will terminate for the surviving spouse and dependents if:

- Surviving spouse remarries. (If the remarriage occurs less than 36 months after the covered employee's or retiree's death, the surviving spouse may have rights under ***COBRA***.)
- Payments are not received when due
- Surviving spouse dies. (If the surviving spouse dies less than 36 months after the employee's or retiree's death, the covered dependents may have the right for ***COBRA*** continuation of coverage.)

The surviving spouse will be responsible for any claims paid on his or her behalf and any dependents behalf as of the date of ineligibility.

The monthly premium payment can be paid through your monthly annuity check or from your banking institution or you may remit a monthly premium to Sandia. For more information contact Sandia ***HBES*** at (505) 844-4237.

Class II Dependent Premium

Class II dependents you enrolled prior to 1987 are included in the premium-share you pay for yourself and your covered Class I dependent(s). Any Class II dependents you enrolled after 1986 are **not** counted as dependents in calculating the family premium, and you will pay a separate Class II premium. You may call Sandia ***HBES*** at (505) 844-4237 for premium-share information.

The ***Pre-Tax Premium Plan*** allows employees to take advantage of the tax savings generated by having any required health care premiums taken out of their paychecks before federal, state, and social security (FICA) taxes are deducted. Your taxable income is reduced because your premiums are not included as income. This is allowable under Section 125 of the ***IRS*** Code.

Once the calendar year has started, you generally cannot change the tax status (that is, from pre-tax to after-tax and vice versa) of your premium-share. However, due to ***IRS*** rules governing pre-tax premiums, individuals not qualifying as tax dependents under the ***IRC*** for purposes of health care coverage must be enrolled individually and cannot be combined as part of the Employee and Spouse; Employee and ***Children***; or Employee, Spouse, and ***Children*** coverage. Separate monthly premiums must be paid to cover these individuals on an after-tax basis. However, if your dependent becomes ineligible as a tax dependent under the ***IRC*** rules for purposes of health care coverage but is still eligible under the health care plans, your pre-tax premiums attributable to that dependent's coverage will be changed to after tax, as you may not pay any portion of their medical plan monthly premiums on a pre-tax basis through the ***Pre-Tax Premium Plan***.

If you elect to have premiums taken on a pre-tax basis for your Class II dependents, and you have a plan dependent who does not meet Section 152 of the ***IRC*** for purposes of medical care coverage, you must notify Sandia ***HBES***, as the premium (if applicable) for that dependent will need to be paid on an after-tax basis, and you will have imputed income. If your dependent does not meet the eligibility criteria for plan coverage, you must disenroll him/her within 31 calendar days. Refer to the ***Pre-Tax Premium Plan*** booklet for more information.

COBRA Premium

Sandia requires persons who elect continuation of the employer-provided medical coverage to pay the full cost of the coverage, plus a two percent administrative charge. The required ***COBRA*** premium is more expensive than the amount that active employees are required to pay; but the ***COBRA*** premium may be less expensive than individual health coverage. ***COBRA*** continuation coverage lasts only for a limited period of time.

As an alternative to electing coverage under the Retiree, ***LTD terminee***, or Surviving Spouse Medical Plan Options, those individuals may choose to continue the active employee medical plan coverage by making the COBRA election. Refer to Section 13, Continuation of Group Health Coverage for more information.

Section 5. Deductible and Maximums

General Information

The following table summarizes the annual ***deductible*** and ***out-of-pocket maximum*** that apply to the in- and out-of-network options, as well as any lifetime maximums under this CIGNA Senior Premier PPO.

Type	In-Network Option			Out-of-Network Option		
Coverage	**Individual**	**Family of two**	**Family of three or more**	**Individual**	**Family of two**	**Family of three or more**
Annual Deductible	None			None		
Annual Out-of-Pocket Maximum	$1,000 per individual					
Lifetime Maximum	$150,000 per person					

Deductible

The CIGNA Senior Premier PPO does not require ***deductibles*** to be met before the covered member receives coverage. Your coverage under this Plan begins with your first covered ***medically necessary*** service.

Out-of-Pocket Maximum

The ***out-of-pocket maximums*** cross-apply between the in-network and out-of-network benefit. CIGNA HealthCare will notify members via an ***Explanation of Benefits*** (***EOB***) when their annual, ***out-of-pocket maximum*** ($1,000) has been reached. With some exceptions (see table below), once the covered member has met his/her ***out-of-pocket maximum***, he/she is not required to pay additional ***coinsurance*** for covered medical services received for the remainder of the calendar year.

The following table identifies what does and does not apply toward the individual in- and out-of-network, ***out-of-pocket maximums***:

Plan Features	Applies to In-Network Out-of-Pocket Maximum?	Applies to Out-of-Network Out-of-Pocket Maximum?
Copays	Not Applicable	Not Applicable
Payments toward the annual deductible	Not Applicable	Not Applicable
Coinsurance payments	Yes	Yes
Charges for non-covered medical services	No	No
Amounts of any reductions in benefits you incur by not following prior authorization or pre-certification requirements*	Not Applicable	Not Applicable
Amounts you pay toward behavioral health services	Yes	No
Charges that exceed eligible expenses	No	No
Prescription drugs obtained through the Prescription Drug Program	No	No
* There may be prior authorization requirements for services that are not covered by *Medicare*.		

Example: In a calendar year, a ***Medicare primary*** retiree may meet the $1,000 ***out-of-pocket maximum*** as follows:

Out-of-Pocket Maximum Example			
	Out-of-Pocket Expenses In-Network	**Out-of-Pocket Expense Out-of-Network**	**Applied to Out-of-Pocket Maximum**
Retiree	$500	$500	$1,000
Total:	**$500**	**$500**	**$1,000**

For the remainder of the calendar year, any additional covered medical expenses submitted by this retiree under either the in-network or out-of-network benefit option will be paid at up to 100% (with some exceptions) of ***eligible expenses***.

Lifetime Maximums

You are subject to a lifetime maximum for medical coverage under this Plan. The lifetime maximum is $150,000 of the employer-paid portion for in- and out-of-network claims combined.

The first $3,500 of the employer-paid benefits, for the calendar year, do not apply to the $150,000 lifetime maximum. In addition, if a member reaches the lifetime maximum, the Plan will continue to pay $3,500 in benefits each year. The ***outpatient*** prescription drug benefits paid under this Plan do not apply to the ***out-of-pocket maximum*** or the lifetime maximum. There is no maximum benefit level under the ***outpatient*** prescription drug coverage.

Section 6. Coverages & Limitations

What the CIGNA Senior Premier PPO Covers

This CIGNA Senior Premier PPO provides a wide range of medical care coverage for you and your family. All coverage is based on medical necessity and whether the service is a ***covered health service*** as defined below.

The following table and the coverage details after the table provide information about the ***covered health services*** under this Plan. The in-network option requires you to obtain care from the CIGNA HealthCare or CIGNA Behavioral Health networks. The out-of-network option allows you to seek care from any licensed provider.

Note: This Plan does not have any preexisting condition limitation which means that if you have a medical condition, such as pregnancy or cancer, before you begin coverage under this plan, there is no waiting period before coverage takes effect under this Plan.

Covered health services are those medical care services and supplies that are:

- Provided for the purpose of preventing, diagnosing, or treating ***illness***, ***injury***, mental ***illness***, ***substance abuse***, or their symptoms
- ***Medically necessary***
- Included in this section (subject to limitations and exclusions as stated in this SPD)
- Provided to a covered member who meets the Plan's eligibility requirements, as described in Section 2, Eligibility.

Plan Highlights

The following table highlights the amounts you will pay for various covered medical services. ***Coinsurance*** is a cost-sharing feature by which both the Plan and the member pay a percentage of the covered ***eligible expense***.

IMPORTANT

*You are responsible for any amount above the **eligible expense** if you receive out-of-network services not covered by **Medicare**.*

It is important for you to know whether your provider accepts ***Medicare*** assignment or not. The ***negotiated fee*** (for in-network services) and the ***U&C*** (for out-of-network services) come into play if a service is not covered by ***Medicare***, such as acupuncture and certain types of preventive care.

If your provider accepts ***Medicare*** assignment, the provider is required to write off any charges that are above the ***Medicare*** allowed amount.

If the provider does not accept ***Medicare*** assignment, the patient is liable for the amount above ***Medicare's*** allowable fee up to ***Medicare's*** limiting charge. The limiting charge is 115 percent of ***Medicare's*** allowed amount. This is for covered benefits under ***Medicare***.

If the service is not a covered benefit under ***Medicare***, the provider charges for services is not limited by ***Medicare's*** limiting charge of 115 percent.

Coinsurance is a cost-sharing feature by which both the Plan and the covered member pay a percentage of the covered ***eligible expense***. The ***coinsurance*** **(20 percent)** is the percentage the member pays of either the ***Medicare Allowable*** or ***negotiated fee*** (in-network) or ***U&C*** (out-of-network). In cases where ***Medicare*** does not cover the service, but the Plan does, the ***coinsurance*** will be based off the ***negotiated fee*** (in-network) or ***U&C*** (out-of-network).

The following table highlights the amounts you will pay for various covered medical care services.

Benefit	In Network Option	Out-of-Network Option
IMPORTANT For detailed benefit provisions and limitations, please refer to the information following this table.		
Acupuncture Services Combined maximum of $1,500/year (in- and out-of-network) with chiropractic benefit	20%	20%
Allergy Services	20%	20%
Ambulance	20%	20%
Behavioral Health Mental health & substance abuse program combined maximum of 90 days/year (in- and out-of-network).	20%	50% and does not apply to the out-of-pocket maximum
Biofeedback Services	20%	20%
Chemotherapy	20%	20%
Chiropractic Services Combined maximum of $1,500/year (in- and out-of-network) with acupuncture benefit	20%	20%
Dental Services	20%	20%
Diagnostic Tests	20%	20%
Durable Medical Equipment	20%	20%
Emergency Room Care	20%	20%
Employee Assistance Program (EAP)	Not Available under this Plan	Not Available under this Plan
Eye Exam (non-refractive care) due to illness or injury to the eye	20%	20%
Eyeglasses/Contact Lenses (initial pair only when required due to the loss of a natural lens)	20%	20%
Family Planning	20%	20%
Hearing Aids/Exam	20%	20%
Home Health Care	20%	20%

Benefit	In Network Option	Out-of-Network Option
IMPORTANT For detailed benefit provisions and limitations, please refer to the information following this table.		
Hospice Services	20%	20%
Infertility Treatment	Not Available under this Plan	Not Available under this Plan
Injections in Physician Office (other than those covered under Preventive Care)	20%	20%
Inpatient Services	20%	20%
Lab	20%	20%
Medical Supplies	20%	20%
Nutritional Counseling	20%	20%
Occupational Therapy	20%	20%
Office Care/Visit	20%	20%
Organ Transplant	20%	20%
Outpatient Surgery	20%	20%
Physical Therapy	20%	20%
Prescription dispensed other than at pharmacy (i.e., physician's office)	20%	20%
Preventive Care	Covered in full	20%
Prosthetic Appliances	20%	20%
Radiation Therapy	20%	20%
Radiology	20%	20%
Rehabilitation Facility	20%	20%
Rehabilitation Services	20%	20%
Skilled Nursing Facility	20%	20%
Speech Therapy	20%	20%
Urgent Care Facilities	20%	20%

Coverage Details

The table above provides information about member's costs for eligible expenses that are covered under this Plan. And the following provides more detailed information of the covered medical services under this Plan.

Acupuncture Services

The Plan covers acupuncture services as follows:

- A maximum combined paid benefit of $1,500 for acupuncture and chiropractic services per calendar year per covered member. This maximum applies to in- and out-of-network acupuncture and chiropractic benefits combined.
- Including X-rays and other services provided by a licensed acupuncturist or Doctor of Oriental Medicine either in or out of network with no review required by CIGNA HealthCare.

Allergy Services

The Plan covers services related to allergies as follows:

- Office visits
- Allergy testing
- Allergy serum
- Allergy shots.

Ambulance Services

The Plan covers ambulance services and transportation provided by a licensed ambulance service as follows:

Ground Ambulance Services

- For ***emergency*** transportation to the nearest ***hospital*** where ***emergency*** health services can be performed
- Transportation from one facility to another is allowable as a covered medical service when ordered by the treating ***physician***
- If there is documentation from the ambulance service that they do not differentiate between advanced life support and basic life support, the Plan will cover the services as billed.

Air Ambulance Services

- Air ambulance is covered only when ground transportation is impossible or would put life or health in serious jeopardy
- Member may be transported by air ambulance to a facility nearest to his/her established home address if the member's condition precludes his/her ability to travel by a non-medical transport
- If the covered member is in line for a transplant and the transplant has been approved by CIGNA HealthCare and there are no commercial flights to the city in which the organ is available, the Plan will cover the medical transport of the patient via air ambulance or a jet (whichever is less expensive).

Other than what is specified above, non-emergency ambulance services are not covered.

Behavioral Health Services

The Plan covers ***outpatient*** mental health and ***substance abuse*** services as follows:

- Evaluations and assessments
- Diagnosis
- Treatment planning
- Referral services
- Medication management
- Individual and group therapeutic services
- Intensive ***outpatient*** therapy programs
- Crisis intervention
- Psychological testing, including neuropsychological testing.

The Plan allows unlimited ***outpatient*** mental health and ***substance abuse*** visits.

The Plan covers ***inpatient*** **and** ***partial hospitalization*** mental health and ***substance abuse*** services as follows.

- Services received on an ***inpatient*** or ***partial hospitalization*** basis in a ***hospital*** or an alternate facility licensed to provide mental health or ***substance abuse*** treatment
- If a member is admitted to a facility and the patient does not meet ***inpatient*** criteria, CIGNA Behavioral Health will review to determine whether the patient meets ***partial hospitalization***. If the member meets ***partial hospitalization*** criteria, only the cost for ***partial hospitalization*** in that area will be allowed with the primary covered member responsible for the remainder of the cost

- If CIGNA Behavioral Health determines that an ***inpatient*** stay is required, it is covered on a semi-private room basis
- If CIGNA Behavioral Health determines that ***partial hospitalization*** is required, then two ***partial hospitalization*** days are counted as one 24-hour hospitalization day.

The Plan covers rehabilitation services at a licensed residential treatment facility as follows:

- 30 days of the 90-day ***inpatient*** day maximum are allowed per calendar year, with the exception of 60 days allowed out of the 90 days for eating disorders
- Up to 120 days of the ***inpatient*** day maximum are allowed in any five consecutive calendar-year time frame
- For any residential treatment stay, there must be at least six hours of therapy provided every calendar day.

Guidelines:

- Services are required to be pre-authorized by CIGNA Behavioral Health if the benefit is not covered by ***Medicare*** (otherwise you incur a $300 penalty).
- Any combination of in-network and out-of-network benefits for mental health services and/or ***substance abuse*** services is limited to ninety (90) days per calendar year.
- If there are multiple diagnoses, the plan will only pay for treatment of the diagnoses that are identified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (APA).
- Medical services provided such as lab or radiology are paid under the medical benefit.
- Wilderness programs, boot-camp type programs, work-camp type programs, or recreational type programs are not covered.

IMPORTANT

Class II dependents *are not eligible for* ***substance abuse*** *benefits.*

Biofeedback Services (not covered by Medicare; therefore, prior authorization required)

The Plan covers biofeedback services as follows:

- For pain, urinary and fecal incontinence
- Up to five biofeedback sessions per lifetime for smoking cessation
- Charges incurred for training

- Charges billed by a licensed chiropractor, physical therapist, occupational therapist, medical doctor, or doctor of osteopathy (charges from other providers will be reviewed for medical necessity)

Cancer Services

The Plan covers oncology services as follows:

- Office visits
- Professional fees for surgical and medical services
- ***Inpatient*** services
- ***Outpatient*** surgical services

For oncology services and supplies to be considered ***covered health services***, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer.

Chiropractic Services (not covered by Medicare; therefore, prior authorization required)

The Plan covers chiropractic services as follows:

- A maximum combined paid benefit of $1,500 for acupuncture and chiropractic services per calendar year per covered member. This maximum applies to in- and out-of-network acupuncture and chiropractic benefits combined.
- X-rays and other services provided by a licensed chiropractor or Doctor of Oriental Medicine either in- or out-of-network with no review required.

Dental Services (not covered by Medicare; therefore, prior authorization required)

The Plan covers dental services due to ***illness*** or ***injury*** when provided by a Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMD) as follows:

- As a result of accidental ***injury*** to sound, natural teeth and the jaw
- As a result of tooth or bone loss due to a medical condition (e.g., osteoporosis, radiation to the mouth, etc.)
- Oral surgery if performed in a ***hospital*** because of a complicating medical condition that has been documented by the attending ***physician***
- Anesthesia, ***hospital***, and/or ambulatory surgical center expenses for dental procedures when services must be provided in that setting due to disability or for young ***children*** as determined by the attending ***physician***

- Dental implants and implant-related surgery are covered in situations where:
  - Permanent teeth are congenitally missing (anodontia), the result of anodontia is impaired function (e.g., chewing/eating), and the implants are not done solely for cosmetic reasons
  - Tooth loss occurs as a result of accidental injury
  - Tooth loss occurs due to a medical condition such as osteoporosis or radiation of the mouth
- Orthognathic surgery limited to documented skeletal Class II and Class III conditions as determined by cephalometric diagnosis, provided the condition:
  - Is both functional and aesthetic
  - In the opinion of CIGNA HealthCare is not adequately treatable by conventional orthodontic therapy
- Dental services related to medical transplant procedures
- Initiation of immunosuppressive therapy
- Direct treatment of cancer or cleft palate

For services that are provided as a result of an accident, initial treatment must have been started within one year of ***injury*** regardless of whether you were covered under a Sandia medical plan or another employer plan.

Dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not covered.

Although dental implants and implant-related surgery may be covered as indicated above, any crowns or other prosthesis required as a result of the implant are not covered. These may be covered under the Sandia Dental Deluxe/Expense Plans.

Diagnostic Tests (tests not covered by Medicare require prior authorization)

The Plan covers diagnostic tests as follows:

- Lab and radiology
- Computerized tomography (CT) scans
- Position emission tomography (PET) scans
- Magnetic resonance imaging (MRI)
- Nuclear medicine
- Echocardiograms
- Electroencephalograms

- Sleep studies, and
- Other diagnostic tests

Durable Medical Equipment (DME)

The Plan covers ***DME*** as follows:

- Ordered or provided by a ***physician*** for ***outpatient*** use
- Used for medical purposes
- Not consumable or disposable
- Not of use to a person in the absence of an ***illness***, ***injury*** or disability
- Durable enough to withstand repeated use
- Appropriate for use in the home

Examples of ***DME*** include:

- Wheelchairs
- ***Hospital*** beds
- Equipment for the treatment of chronic or acute respiratory failure or conditions
- Equipment to administer oxygen
- Oxygen
- Orthopedic shoes
    - Up to two pairs of custom-made orthopedic shoes are covered per year when necessary due to ***illness*** such as diabetes, post polio, or other such conditions
- Mastectomy bras:
    - Up to two per calendar year will be allowed following a mastectomy
- C-PAP machine
- Bilirubin lights

The Plan will allow one educational training session to learn how to operate the ***DME***, if required. Additional sessions will be allowed if there is a change in equipment.

If ***Medicare*** will not pay for more than one piece of ***DME***, the Plan will allow more than one piece of ***DME*** if deemed ***medically necessary*** by CIGNA HealthCare (e.g., an oxygen tank in the home and a portable oxygen tank).

Benefits are provided for the replacement of a type of ***DME*** once every three years, except as otherwise stated.

CIGNA HealthCare will decide if the equipment should be purchased or rented and you must purchase or rent the ***DME*** from the vendor CIGNA HealthCare identifies.

If the ***DME*** is purchased/owned and it is lost or stolen, the Plan will not pay for replacement unless the ***DME*** is at least three years old. If the ***DME*** is leased or rented, the Plan will not pay for replacement; however, some rental agreements may cover it if lost or stolen. If the ***DME*** breaks or is otherwise irreparable as a result of normal use, the Plan will pay for a replacement.

Emergency Care

If you have an *emergency*, go to the nearest *hospital emergency* room. These facilities are open 24 hours a day, seven days a week.

The Plan will cover ***medical emergency*** care worldwide as follows:

- Received within or outside the United States
- Behavioral health services at the in-network level of benefit
- Non-emergency services received in an ***emergency*** room within or outside the United States
- ***Follow-up care*** that results from a ***medical emergency*** while on travel within or outside the United States.

Employee Assistance Program

Not available under this Plan.

Eye Exam/Eyeglasses/Contact Lenses

The Plan covers eye exams (non-refractive care) due to ***illness*** or ***injury*** of the eye such as conjunctivitis, diabetic retinopathy, glaucoma, and cataracts.

The Plan pays for an initial pair of contact lenses or glasses when required due to the loss of a natural lens or cataract surgery.

Family Planning (not covered by Medicare; therefore, prior authorization required)

The Plan covers family planning services as follows:

- Sterilization procedures such as vasectomies and tubal ligations
- ***Medically necessary*** ultrasounds and laparoscopies

- Family planning devices that are implanted or injected by the ***physician*** such as intrauterine devices (IUDs), Norplant, or Depo-provera
- Reversals of prior sterilizations
- Surgical, non-surgical or drug induced pregnancy termination
- Health services and associated expenses for elective and therapeutic abortion.

Diaphragms and any other birth control obtained at a pharmacy are eligible for coverage under the Prescription Drug Program.

Hearing Aids/Exam

The Plan will cover the initial purchase and exam when required due to sudden ***injury*** or ***illness***. Natural hearing loss is not covered. Refer to the Preventive Care section for information on hearing screenings.

Home Health Care Services

Covered health services are services that a home health agency provides if you are homebound due to the nature of your condition. Services must be:

- Ordered by a ***physician***
- Provided by or supervised by a registered nurse in your home
- Not considered custodial in nature
- Provided on a part-time, intermittent schedule when skilled home health care is required.

Hospice Services

Hospice care is an integrated program recommended by a ***physician*** that provides comfort and support services for the terminally ill. ***Hospice*** care can be provided on an ***inpatient*** or ***outpatient*** basis and includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available only when ***hospice*** care is received from a licensed ***hospice*** agency or ***hospital***.

Infertility Services

Not available under this Plan.

Injections in Physician's Office

This Plan covers injections in a ***physician's*** office as follows:

- Allergy shots – 20% of ***eligible expenses***
- Immunizations/vaccines – no cost to you as outlined under the Preventive Care benefit in this Section
- All other injection (e.g., cortisone, depo-provera, etc.) – 20% of ***eligible expenses***.

Inpatient Care/Services

An ***inpatient*** stay is defined as a ***hospital*** stay of 24 hours or more. If a ***hospital*** stay is billed as ***inpatient*** with charges for room and board, it will be considered ***inpatient***. If a ***hospital*** stay is billed as ***outpatient***, no room and board charges will be considered.

The Plan covers ***inpatient*** care in a ***hospital*** as follows:

- Services and supplies received during an ***inpatient*** stay
- Room and board in a semi-private room (a room with two or more beds)
- Intensive care.

The Plan will pay the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice as determined by CIGNA HealthCare or CIGNA Behavioral Health.

Benefits for an ***inpatient*** stay in a ***hospital*** are available only when the ***inpatient*** stay is necessary to prevent, diagnose, or treat an ***illness*** or ***injury***.

Maternity Services (not covered by Medicare; therefore, prior authorization required)

Refer to the CIGNA Premier PPO Summary Plan Description for information on what is considered a covered health service.

Medical Supplies

The Plan covers certain medical supplies to include, but not limited to items such as:

- Ostomy supplies
- Therapeutic devices and appliances such as blood glucose monitors, respiratory therapy devices, etc.
- Lancet auto-injectors
- Insulin pumps
- Compression stockings

Lancets, alcohol swabs, diagnostic testing agents, syringes, novopen, insulin auto-injectors, and allergic ***emergency*** kits can be obtained through the Prescription Drug Program.

Nutritional Counseling (dietician services not covered by Medicare require prior authorization)

The Plan covers certain services provided by a registered dietician in an individual session if you have a medical condition that requires a special diet. Some examples of such medical conditions include:

- Diabetes mellitus
- Coronary artery disease
- Congestive heart failure
- Severe obstructive airway disease
- Gout (a form of arthritis)
- Renal failure
- Phenylketonuria (a genetic disorder diagnosed at infancy)
- Hyperlipidemia (excess of fatty substances in the blood).

Obesity Surgery (not covered by Medicare; therefore, prior authorization required)

The Plan covers surgical treatment of ***morbid obesity*** received on an ***inpatient*** basis provided all of the following are true:

- You have a minimum Body Mass Index (BMI) of 40
- You have documentation from a ***physician*** of a diagnosis of ***morbid obesity*** for a minimum of five years
- You are over the age of 21.

Office Care/Visits

The Plan pays for the following services provided in the ***physician's*** office:

- Consultations
- Second opinions
- Post-operative follow-up
- Services after hours
- ***Emergency*** office visits

- Allergy testing
- Office surgery
- Chemotherapy
- Radiation therapy
- Radiology services
- Diagnostic tests
- Laboratory services
- Supplies

Organ Transplants

The Plan covers ***inpatient*** facility services (including evaluation for transplant, organ procurement, and donor searches) for the following transplantation procedures when the transplant meets the definition of a ***covered health service*** and is not ***experimental*** or ***investigational***, or unproven:

- Heart
- Heart/lung
- Lung
- Lidney
- Kidney/pancreas
- Liver
- Liver/kidney
- Liver/intestinal
- Pancreas
- Intestinal
- Bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high-dose chemotherapy. Not all bone marrow transplants meet the definition of a ***covered health service*** – see below.

The search for bone marrow/stem cells from a donor who is not biologically related to the patient is a ***covered health service***. If a separate charge is made for a bone marrow/stem cell search, the Plan will pay up to $25,000 for all charges made in connection with the search.

Outpatient Surgical Services

The Plan covers ***outpatient surgery*** (other than in a ***physician's*** office) and related services as follows:

- Facility
- Anesthesia
- Supplies related to the surgery
- Equipment related to the surgery.

Benefits for the professional fees are described under Professional Fees for Surgical and Medical Services in this section.

Prescription Drugs (other than those dispensed by the Prescription Drug Program)

The Plan will cover prescription drugs under the medical plan as follows:

- Enteral nutrition for diagnosis of dysphagia (difficulty swallowing) as the sole source of nutrition, or in the case of genetic disorder of Phenylketonuria (PKU), or in cases of RH factor disorders
- Intravenous medications
- Medication that is dispensed and/or administered by a licensed facility or provider such as a ***hospital***, home health care agency, or ***physician's*** office, and the charges are included in the facility or provider bill.

Preventive Care

The Plan will not cover all care that is preventive in nature. This preventive care coverage that is provided under this Plan is outlined below.

Clarification on Routine Physical Exam Benefit:

In order for the physical exam to be covered under the preventive benefit, the provider must bill with a routine physical/preventive diagnosis code; otherwise the service will be reimbursed at the applicable ***coinsurance***.

One physical/annual exam will be allowed each calendar year which may be an annual routine physical exam or sports physical.

The annual routine physical exam is also available to members with any type of chronic ***illness*** or condition such as high blood pressure, diabetes, etc.

It is solely up to the provider as to whether the service is coded as preventive or diagnostic. Neither Sandia nor the CIGNA HealthCare can direct the provider to bill a service in any particular way. This issue as to how it is billed is between you and your provider.

Routine Physical Exams

Well-Baby Care (0-2 years)

Refer to the CIGNA Premier PPO SPD for covered preventive well-baby care.

Well-Child Care (3-10 years)

Refer to the CIGNA Premier PPO SPD for covered preventive well-child care.

Well-Adolescent Care (11-18 years)

Refer to the CIGNA Premier PPO SPD for covered preventive well-adolescent care.

Well-Adult Care (19 years of age and older)

- Routine annual physical exam and one well-woman exam per calendar year (including height, weight, and blood pressure)
- Chlamydia screen (annually as needed)
- Rubella screen (limited to one per lifetime)
- Sexually transmitted diseases screening (as needed)

Immunizations/Flu Shot Services

The Plan will pay 100% of in-network eligible expense and 80% of the out-of-network eligible expense charge, after the ***deductible***, for flu shots, pneumococcal vaccine, and immunizations related to personal travel. If you are unable to obtain the type of immunization required at the ***physician's*** office (e.g., malaria pills), in Albuquerque, NM, you can go to Concentra at 3800 Commons NE, (505) 822-9480, and receive in-network

benefits. If you need to obtain different types of immunizations for personal travel where at least one of these is not available at a ***physician's*** office, you may obtain all of your immunizations at Concentra. If you are located anywhere else in the United States, contact CIGNA HealthCare at 1-800-244-6224 for assistance.

IMPORTANT

It is solely up to the provider as to whether it is coded as preventive or diagnostic. Neither Sandia nor CIGNA HealthCare can direct the provider to bill a service in any particular way. The issue as to how it is billed is between you and your provider.

Laboratory Services

The Plan will pay 100% of the in-network eligible expense and 80% of the out-of-network eligible expense, after the ***deductible***, for the following laboratory services for members age 19 and older:

- Complete blood count (CBC) with differential, which includes white blood count, red blood count, hemoglobin, hematocrit, platelet, mcv, mchc, rdw. Differential includes neutrophils, lymphocytes, monosite, eosinophil, basophile, absolute neutrophil, absolute lymphocyte, absolute monocyte, absolute eosinophile, absolute basophile, diff type, platelet estimate, red blood cell morphology
- Complete urinalysis, which includes source, color, appearance, specific gravity, urine PH, protein, urine glucose, urine ketones, urine bilirubin, blood, nitrate, urobilinogen, leukocyte estrase, red blood count, white blood count, squamos epithelial, calcium oxylate
- Complete metabolic profile, which includes sodium, potassium, chloride, CO_2, anion, glucose, bun, creatinine, calcium, total protein, albumin, globulin, bilirubin total, alkphos, asp, alt
- Diabetes screening, which includes a two-hour postprandial blood sugar and HbA1c
- Thyroid screening, which includes free T4 and TSH
- Lipid panel which includes triglycerides, total cholesterol, HDL, and calculated LDL cholesterol

As ordered by the ***physician***, covered members are entitled to one of each of the above category once every calendar year. In order to receive the preventive care benefit, the laboratory service must be submitted with a preventive ***ICD-9*** code. If it is submitted with a diagnostic code other then the preventive ***ICD-9*** code, the service will be reimbursed at the applicable benefit level.

If the ***physician*** orders one or more components within one of the above categories but not the complete set, and it is submitted with a preventive code, it will be paid under the preventive benefit.

IMPORTANT

It is solely up to the provider as to whether it is coded as preventive or diagnostic. Neither Sandia nor CIGNA HealthCare can direct the provider to bill a service in any particular way. This issue as to how it is billed is between you and your provider.

Cancer Screening Services

For the following services, the Plan will pay 100% of the in-network eligible expense and 80% percent of the out-of-network ***eligible expense*** after the deductible:

Service	Allowed Frequency	Allowable Age
Pap test	Annual	14
Prostate Antigen test	Annual	50
Mammogram*	Baseline Annual	Between 35-39 40
Fecal occult blood test	Annual	50
Sigmoidoscopy**	Once every five years	50
Colonoscopy**	Once every 10 years	50
Barium enema**	Once every five years	50

* High-risk women with an immediate family (mother or sister) member history of breast cancer are eligible for an annual mammogram upon reaching age 25. The mammogram preventive benefit also includes the computer-aided detection test. The preventive benefit also includes the charge by the provider for interpreting the test results.

** You are entitled to the following:

- A sigmoidoscopy once every five years, OR
- A colonoscopy once every 10 years, OR
- **Note:** A sigmoidoscopy or colonoscopy will be allowed if under age 50 or more frequently if you have an immediate family (mother, father, sister, brother only) member history of colorectal cancer.
- A barium enema will be allowed once every five years in lieu of a colonoscopy or sigmoidoscopy.

The preventive benefit also includes the charge by the provider for interpreting the test results.

In order to receive the preventive care benefit, the service must be submitted with a preventive ***ICD-9*** code. If it is submitted with a non-preventive ***ICD-9*** code, the service will be reimbursed at the applicable benefit level.

IMPORTANT

It is solely up to the provider as to whether it is coded as preventive or diagnostic. Neither Sandia nor CIGNA HealthCare can direct the provider to bill a service in any particular way. This issue as to how it is billed is between you and your provider.

Pregnancy Related Preventive Care Services

Refer to the CIGNA Premier PPO SPD for information on covered medical services for pregnancy related preventive care.

Bone Density Testing

The Plan will pay 100% of the in-network ***eligible expense*** and 80% of the out-of-network eligible expense after the deductible for bone-density testing once every three years upon reaching 50 years of age.

IMPORTANT

It is solely up to the provider as to whether the service is coded as preventive or diagnostic. Neither Sandia nor CIGNA HealthCare can direct the provider to bill a service in any particular way. This issue as to how it is billed is between you and your provider.

Prosthetic Devices/Appliances

The Plan covers prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- Artificial limbs
- Artificial eyes
- Breast prosthesis following a mastectomy (as required by the Women's Health and Cancer Rights Act of 1998), including mastectomy bras (see ***DME***) and lymphedema stockings. There are limitations on the number of prosthesis and no time limitations from the date of the mastectomy.

If more than one prosthetic device can meet your functional needs, benefits are available only for the most ***cost effective*** prosthetic device. The device must be ordered or provided either by a ***physician***, or under a ***physician's*** direction.

If the prosthetic device or appliance is lost or stolen, the Plan will not pay for replacement unless the device or appliance is at least five years old. If the device or appliance breaks or is otherwise irreparable, the Plan will pay for a replacement.

Professional Fees for Surgical and Medical Procedures

The Plan pays professional fees for surgical procedures and other medical care received from a ***physician*** in a ***hospital***, ***skilled nursing care facility***, ***inpatient*** rehabilitation facility, or ***outpatient surgery facility***.

The Plan will pay the following surgical expenses:

- Only one charge is allowed for the operating room and for anesthesia

- A surgeon will not be paid as both a co-surgeon and an assistant surgeon
- Expenses for certified first assistants are allowed
- A surgical procedure that is performed and not considered incidental to the primary procedure will be reimbursed at half of the allowable. For example, when bilateral surgical procedures are performed by one or two surgeons, the Plan will consider the first procedure at the full allowed amount, and the second procedure will be considered at half of the allowed amount of the listed surgical unit value.
- Incidental procedures are those services carried out at the same time as a more complex, primary procedure. The incidental procedure may be a part of the primary procedure and requires little or very little additional time and resources; therefore, they are not covered.
- Foot surgery – for a single surgical field/incision or two surgical fields/incisions on the same foot, the Plan will allow the full amount for the procedure commanding the greatest value; half of the full amount for the second procedure; half of the full amount for the third procedure; and a quarter of the full amount for each subsequent procedure. Also, if procedure 11721 is billed in conjunction with 10056 and 10057, these will be allowed to be reimbursed separately without bundling when billed with a medical diagnosis.

Reconstructive Procedures

The Plan covers certain ***reconstructive procedures*** where a physical impairment exists and the expected outcome is restored or improved physiologic function for an organ or body part.

IMPORTANT

The fact that a member may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a ***reconstructive procedure****.*

Improving or restoring physiology function means that the organ or body part is made to work better. An example of a ***reconstructive procedure*** is surgery on the inside of the nose so that a person's breathing can be improved or restored. There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Upper eyelid surgery when done to improve vision is considered a ***reconstructive procedure***. If the primary intended purpose is to improve appearance, the procedure is considered a ***cosmetic procedure*** and is not covered under this Plan.

Benefits for ***reconstructive procedures*** include breast reconstruction following a mastectomy. Coverage by this plan is provided for all stages of reconstruction of the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. Replacement of an existing breast implant is covered if the initial breast implant followed a mastectomy.

Rehabilitation Services (Outpatient Therapies) (not covered by Medicare; therefore, prior authorization required)

The Plan provides ***outpatient*** rehabilitation services for the following types of therapy:

- Physical
- Occupational
- Speech
- Pulmonary rehabilitation
- Cardiac rehabilitation.

Rehabilitation services must be provided by a licensed therapy provider and under the direction of a ***physician***. Physical, occupational, and speech therapies are subject to reimbursement with demonstrated improvement as determined by CIGNA HealthCare. Maintenance therapy is not covered.

> **Note:** This Plan covers speech, physical, and occupational therapies rendered for developmental disorders until the patient is at a maintenance level of care as determined by CIGNA HealthCare.

Manual therapy techniques for lymphatic drainage, including manual traction, etc., are covered when performed by a licensed chiropractor, physical therapist, or ***physician***.

Predetermination with CIGNA HealthCare is recommended.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an ***inpatient*** stay in a ***skilled nursing care facility*** or ***inpatient*** rehabilitation facility are covered under the Plan. Benefits include:

- Services and supplies received during the ***inpatient*** stay
- Room and board in a semi-private room (a room with two or more beds)

The Plan will pay the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice as determined by CIGNA HealthCare.

Benefits are available when skilled nursing and/or ***inpatient*** rehabilitation facility services are needed on a daily basis. Benefits are also available in a ***skilled nursing care facility*** or ***inpatient*** rehabilitation facility for treatment of an ***illness*** or ***injury*** that would have otherwise required an ***inpatient*** stay in a ***hospital***.

The intent of skilled nursing is to provide benefits if, as a result of an ***injury*** or ***illness***, you require:

- An intensity of care less than that provided at a general acute ***hospital*** but greater than that available in a home setting or
- A combination of skilled nursing, rehabilitation, and facility services

The Plan does not pay benefits for ***custodial care***, even if ordered by a ***physician***.

Temporomandibular Joint (TMJ) Syndrome

The Plan covers diagnostic and surgical treatment of conditions, including appliances, affecting the temporomandibular joint when provided by or under the direction of a ***physician***. Coverage includes necessary treatment required as a result of accident, trauma, a ***congenital anomaly***, developmental defect, or pathology.

Urgently Needed Care

The Plan will cover ***urgent care*** worldwide as follows:

- Received in an ***urgent care facility*** within or outside the United States
- ***Follow-up care*** that results from urgently needed care while on travel within or outside the United States.

Section 7. Exclusions

What this CIGNA Senior Premier PPO Does Not Cover

Although the CIGNA Senior Premier PPO Plan provides benefits for a wide range of ***covered health services***, there are specific conditions or circumstances for which the CIGNA Senior Premier PPO Plan will not provide benefit payments. In general, the Plan will not pay for any expense that is primarily for the member's convenience or comfort or that of the member's family, caretaker, ***physician***, or other medical provider.

Plan Exclusions

You should be aware of these exclusions that include but are not limited to items in the following table.

Exclusions	Examples
Administrative fees, penalties, and limits	• Charges that exceed what CIGNA HealthCare determines are eligible expenses • Insurance filing fees, attorney fees, physician charges for information released to CIGNA HealthCare and other service charges and finance or interest charges • Charges incurred for services that are not within the scope of a provider's licensure • Amount you pay as a result of failure to contact CIGNA HealthCare for prior authorization including unauthorized care • Charges for missed appointments
Behavioral Health Services	• Family therapy including marriage counseling and bereavement counseling • Conduct disturbances unless related to a coexisting condition or diagnosis otherwise covered • Educational, vocational, and/or recreational services as outpatient procedures • Biofeedback for treatment of diagnosed medical conditions • Treatment for learning disabilities and pervasive developmental disorders (including autism) other than diagnostic evaluation • Treatment for insomnia, other sleep disorder, dementia, neurological disorders, and other disorders with a known physical basis (certain treatments may be covered under the medical portion of the Plan) • Treatment that is determined by CIGNA Behavioral Health to be for the member's personal growth or enrichment • Court-ordered placements when such orders are inconsistent with the recommendations for treatment of CIGNA Behavioral Health

Exclusions	Examples
	• Services to treat conditions that are identified by the most current edition of the Diagnostic and Statistical Manual of Mental Disorders as not being attributable to a mental disorder • Sex transformations • Services or supplies that are not medically necessary • Custodial care • Pastoral counseling • Developmental care • Treatment for caffeine or tobacco addiction, (with the exception of hypnotherapy and biofeedback for tobacco addiction), withdrawal, or dependence • Aversion therapies • Treatment for codependency • Non-abstinence-based or nutritionally-based treatment for substance abuse • Services, supplies, or treatments that are covered for benefits under the medical benefit • Treatment or consultations provided via telephone. Exception would be for transition of care or interim care for no more than a six (6) months maximum period • Services, treatments, or supplies provided as a result of any Worker's Compensation law or similar legislation, or obtained through, or required by, any government agency or program, whether federal, state, or any subdivision thereof, or caused by the conduct or omission of a third party for which the member has a claim for damages or relief, unless the member provides CIGNA Behavioral Health with a lien against such claim for damages or relief in a form and manner satisfactory to CIGNA Behavioral Health • Non-organic erectile dysfunction (psychosexual dysfunction) • Treatment for conduct and impulse control disorders, personality disorders, paraphilias (unusual sexual urges) and other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by CIGNA Behavioral Health • Services or supplies that are considered experimental or investigational drugs, devices, treatments, or procedures or that result from or relate to the application of such experimental or investigational drugs, devices, treatments, or procedures • Wilderness programs, boot-camp-type programs, work-camp-type programs, or recreational type programs

Exclusions	Examples
	• Services or supplies that are primarily for the covered member's education, training, or development of skills needed to cope with an injury or illness • Substance abuse benefits for Class II dependents
Congenital Heart Disease (CHD)	CHD services other than as listed below are excluded from coverage unless determined by CIGNA HealthCare to be proven procedures for the involved diagnoses: • Outpatient diagnostic testing • Evaluation • Surgical interventions • Interventional cardiac catheterizations (insertion of a tubular device in the heart) • Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology) • Approved fetal interventions
Dental procedures	Dental procedures are not covered under this Plan except for injuries to sound, natural teeth, the jaw bone, or surrounding tissue or birth defects. Treatment must be initiated within 12 months of injury. Dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not covered.
Drugs	Outpatient prescription drugs including drugs obtained that are self-administered are covered under the Prescription Drug Program except drugs dispensed, administered, and billed through the provider or facility that is approved by CIGNA HealthCare for coverage, and all intravenously administered medications.
Equipment	• Exercise equipment (e.g., exercycles, weights, etc.) • Hearing aids for hearing loss (see benefit under "hearing aids" for illness and injury coverage) • Braces prescribed to prevent injuries while you are participating in athletic activities • Household items, including but not limited to: ○ Air cleaners and/or humidifiers ○ Bathing apparatus ○ Scales or calorie counters ○ Blood pressure kits ○ Water beds • Personal items, including but not limited to: ○ Support hose, except medically necessary surgical or compression stockings ○ Foam cushions

Exclusions	Examples
	○ Pajamas • Items payable under the Prescription Drug Program • Equipment rental fees above the purchase price, with the exception of oxygen equipment
Experimental or investigative treatment	Experimental or investigative drugs, devices, medical treatments or procedures, and any related services
Hospital fees	• Expenses incurred in any federal hospital, unless the covered member is legally obligated to pay • Hospital room and board charges in excess of the semi-private room rate unless medically necessary and approved by CIGNA HealthCare or CIGNA Behavioral Health • In-hospital personal charges (e.g., telephone, barber, TV service, toothbrushes, slippers)
Hypnotherapy	Hypnotherapy is not a covered health service with the exception that the Plan allows up to five visits per lifetime for smoking cessation.
Miscellaneous	• Eye exams or eye refractions, except for non-refractive care due to illness or injury to the eye • Eyeglasses or contact lenses prescribed, **except** when required due to loss of a natural lens. Contact lenses are not considered a prosthetic device • Employee Assistance Program benefits • Treatment of infertility • Parenting, prenatal or birthing classes • Over-the-counter medications for birth control/prevention • Modifications to vehicles and houses for wheelchair access • Health club memberships and programs or spa treatments • Treatment or services: ○ incurred when the patient was not covered under this Plan even if the medical condition being treated began before the date your coverage under the Plan ends ○ for illness or injury resulting from the covered member's intentional acts of aggression, including armed aggression, except for injuries inflicted on an innocent bystander (e.g., you did not start the act of aggression) ○ for job-incurred injury or illness for which payments are payable under any Workers' Compensation Act, Occupational Disease Law, or similar law ○ while on active military duty ○ that are reimbursable through any public program other than Medicare or through no-fault automobile insurance

Exclusions	Examples
	• Charges in connection with surgical procedures for sex changes • Charges for blood or blood plasma that is replaced by or for the patient • Conditions resulting from insurrection, except for injuries inflicted on an innocent bystander who is a covered member under this Plan • Christian Science practitioners and facilities • Food of any kind unless it is the only source of nutrition, there is a diagnosis of dysphagia (difficulty swallowing), or in cases of PKU or RH factor • Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk • Foods to control weight, treat obesity (including liquid diets), lower cholesterol, or control diabetes • Oral vitamins and minerals (with the exception of oral calcium supplements for clinically documented hypoparathyroidism and Niferex and certain prescription vitamins) • Herbs and over-the-counter medications except as specifically provided under the Plan • Charges prohibited by federal anti-kickback or self-referral statutes • Chelation therapy, except to treat heavy metal poisoning • Diagnostic tests that are: ○ Delivered in other than a physician's office or health care facility ○ Self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests • Domiciliary care • Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for ten seconds or longer). Appliances for snoring are always excluded. • Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments when: ○ Required solely for purposes of career, education, camp, employment, insurance, marriage, or adoption; or as a result of incarceration ○ Conducted for purposes of medical research ○ Related to judicial or administrative proceedings or order ○ Required to obtain or maintain a license of any type • Private duty nursing received on an inpatient basis • Respite care • Rest cures

Exclusions	Examples
	• Storage of blood, umbilical cord or other material for use in a covered health service, except if needed for an imminent surgery
Not a covered health service and/or not medically appropriate	Treatments or services determined not to be medically necessary and not a covered health service by CIGNA HealthCare or CIGNA Behavioral Health
Old claims	Claims received 12 months after the date when charges were incurred
Physical Appearance	• Breast reduction/augmentation except after breast cancer and/or if medically necessary • Any loss, expense, or charge that results from cosmetic or reconstructive surgery, except after breast cancer. Exceptions to this exclusion include: ○ repair of defects that result from surgery for which the member was paid benefits under the policy, or ○ reconstructive (not cosmetic) repair of a congenital defect that materially corrects a bodily malfunction. **Note:** For the purposes of this exclusion, poor self-image or emotional or psychological distress do not constitute a bodily malfunction. • Liposuction • Pharmacological regimes • Nutritional procedures or treatments • Tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery, and other such skin abrasion procedures) • Replacement of an existing intact breast implant unless there is documented evidence of silicon leakage • Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation • Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity • Wigs regardless of the reason for hair loss • Treatments for hair loss
Provider Services	• Performed by a provider who is a family member by birth or marriage, including your spouse, brother, sister, parent, or child • A provider may perform on himself or herself • Performed by a provider with your same legal residence • Provided at a diagnostic facility (hospital or otherwise) without a written order from a provider and • Ordered by a provider affiliated with a diagnostic facility (hospital or otherwise) when that provider is not actively involved in your medical care: ○ prior to ordering the service or

Exclusions	Examples
	○ after the service is received ○ this exclusion does not apply to mammography testing
Services, supplies, therapy, or treatments	• custodial in nature • otherwise free of charge to the member • furnished under an alternative medical plan provided by Sandia • for aromatherapy or rolfing (holistic tissue massage) • for "developmental care" after a maintenance level of care has been reached • for maintenance care • for massage therapy unless performed by a licensed chiropractor, physical therapist, or physician as a manual therapy technique for lymphatic drainage • for educational therapy when not medically necessary • for educational testing • for smoking cessation programs, except for biofeedback and hypnotherapy, which are limited to a maximum of five visits each per lifetime • for surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia, and astigmatism including but not limited to procedures such as laser and other refractive eye surgery and radial keratotomy
Surgical and non-surgical treatment for obesity	• Surgical operations for the correction of morbid obesity determined by CIGNA HealthCare not to be medically necessary to preserve the life or health of the member • Over-the-counter treatment for appetite control, food addictions, or eating disorders that are not documented cases of bulimia or anorexia meeting standard diagnostic criteria as determined by CIGNA HealthCare/CIGNA Behavioral Health
Transplants	• Organ and tissue transplants, including multiple transplants: ○ Except as identified under Section 6, Coverages and Limitations ○ Determined by CIGNA HealthCare not to be proven procedures for the involved diagnoses and ○ Not consistent with the diagnosis of the condition • Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available) • Donor costs for organ or tissue transplantation to another person unless the recipient is a covered member under this Plan
Transportation	• Non-emergency ambulance services other than those listed in Section 6, Coverages and Limitations

Section 8. Accessing Care

This section outlines how to access care under the in-network and out-of-network options available under this Plan. It also provides information you will need to know when accessing care under this Plan.

You may choose a ***primary care physician*** (***PCP***) to be your personal ***physician***. Your ***PCP*** can serve your basic care needs and may be able to provide valuable advice and direction in addition to coordinating your care.

In-Network Option

The network available to members in this Plan is called Open Access Plus. This is a national network of physicians, facilities, and suppliers who are contracted with CIGNA HealthCare and CIGNA Behavioral Health. CIGNA HealthCare negotiates discounts with their network of ***participating providers***, which results in lower out-of-pocket costs to you.

When you use the in-network option under this Plan, all services and supplies covered must be acquired from the ***physicians***, facilities, and suppliers who are contracted with CIGNA HealthCare and CIGNA Behavioral Health (CBH), be medically necessary, and be an ***eligible expense*** under this Plan. Refer to Section 6, Coverages and Limitations for coverage details.

Some procedures that are not covered by ***Medicare*** may require ***prior authorization*** or ***pre-certification***, which you are responsible for asking your ***physician*** to obtain from CIGNA HealthCare or CBH. For the most up-to-date in-network provider listings in your area, contact CIGNA HealthCare at 1-800-244-6224 or visit CIGNA HealthCare website at www.cigna.com.

The advantages of using the in-network option under this Plan include:

- No responsibility for amounts exceeding ***eligible expenses***
- Generally, no claims to file.

Out-of-Network Options

The out-of-network option offers a lower level of benefit, but enables the covered member to self-direct their care with any licensed providers outside the Plan network. When the member self-directs care, the member is responsible for:

- Paying all costs up front depending on provider's payment policy

- Paying ***deductibles*** and ***coinsurance*** before the plan provides coverage as well as pay any amounts exceeding ***eligible expenses***
- Filing all claims not filed by the provider
- Obtaining ***prior authorization*** or ***pre-certification*** for all ***hospital*** care and certain medical and behavioral health care (if not covered by ***Medicare***) in order to be eligible for full benefits

You can access either the in-network or the out-of-network option at any time you need medical care.

Out-of-Area Coverage

Covered member who live outside of a 30-mile radius from where CIGNA HealthCare and/or CBH have a contracted provider will be provided ***out-of-area coverage***. Those covered members will be able to go to an out-of-network provider, and have their claims processed at an in-network level of coverage.

CIGNA HealthCare will make the determination of who qualifies for the ***out-of-area coverage***.

Prior Authorization

The purpose of ***prior authorization*** is that it:

- Allows you to know in advance whether a procedure, treatment, or service will be covered under your plan
- Helps ensure that you receive the appropriate level of care in the appropriate setting
- Enables CIGNA HealthCare to identify situations that may allow you to receive additional attention (e.g., referrals to disease or case management programs) based on the type of service requested

To receive maximum benefits under this Plan, the provider (for in-network care) or you (for out-of-network care) must obtain ***prior authorization*** for certain benefits that are not covered by ***Medicare***. It is the covered member's responsibility to check with the provider to ensure that this requirement is met. If ***prior authorization*** is not obtained when required, and this Plan is your primary coverage, then a $300 penalty will apply. This means that the first $300 of the claim will not be paid.

If your ***physician*** and CIGNA HealthCare do not agree in advance on the need of services or treatment, the covered member can appeal the decision by asking that CIGNA HealthCare review the situation. Appeal procedures are listed in Section 11, Claims and Appeals.

Regardless of the decision and/or recommendation of CIGNA HealthCare, or what the plan will pay, it is always up to the covered member and the doctor to decide what, if any, care he/she receives. CIGNA HealthCare does not provide medical advice.

IMPORTANT

*Just because a service or procedure does not require **prior authorization** or **pre-certification** does not mean that it is a covered benefit. In order to ensure that services and procedures are covered, you are encouraged to obtain predetermination of benefits.*

Obtain ***prior authorization, pre-certification,*** or predetermination of benefits by calling CIGNA HealthCare at 1-800-244-6224.

The following services require ***prior authorization*** to receive the highest level of benefits unless you have another plan as your primary coverage.

- ***Hospital*** stay:
  - ***Inpatient***—seven days in advance notice
  - Emergency hospitalization—call within two working days after admission
- Surgical Procedures:
  - ***Inpatient*** or ***outpatient***—seven days in advance notice
  - ***Emergency*** surgery-call within two working days of procedure
  - ***Outpatient pre-certification***. The following list of services requiring ***pre-certification*** is updated from time to time. Your physician may obtain the most current list of services requiring ***pre-certification*** from CIGNA HealthCare at 1-800-244-6224:
    - Acupuncture
    - Air ambulance services
    - Back/spine
    - Biofeedback
    - Carpal tunnel release
    - Cochlear implants
    - Dental service stemming from an accident or illness
    - **Durable Medical Equipment**
    - Endometrial ablations
    - External prosthetic appliances (some codes)
    - Home health care
    - Home infusion therapy
    - ***Hospice*** care

- Hysterectomy
- Injectable medications
- Insulin pumps
- Knee arthroscopy
- MRI, CT and PET scans
- Observation stays, excluding false labor for undelivered obstetric patients
- Orthognathic procedures
- Orthotics
- Pelvic laparoscopy
- Pulmonary and cardiac rehabilitation
- Skilled nursing facility
- Speech therapy
- Temporomandibular joint syndrome procedures
- Tonsillectomy with or without adenoidectomy
- Transplantation services
- Tympanostomy tube insertion
- Uvulopalatopharyngoplant (UPP) or laparoscope-aided UPP
- Varicose veins treatment

○ ***Behavioral health—inpatient*** or ***outpatient*** care (except for initial visit)

IMPORTANT

The first $300 of ***covered charges*** *will not be reimbursed if you or a family member do not obtain required* ***prior authorization/pre-certification*** *from CIGNA HealthCare, or fail to notify CIGNA HealthCare within the required time frame for hospitalization, surgeries, and other procedures listed above. An exception to this requirement would be for a covered member who has primary health care coverage under another non-Sandia health care plan.*

Predetermination of Benefits

This Plan covers a wide range of medical care treatments and procedures. However, medical treatments that are ***investigational***, ***experimental***, or unproven to be medically effective are not covered under this Plan. Contact CIGNA HealthCare or CBH before incurring charges that may not be covered under this Plan.

Some services may not be covered under certain circumstances (see Section 7, Exclusions) and may be limited in scope, such as but not limited to acupuncture, chiropractic, speech therapy, occupational therapy, physical therapy, temporomandibular joint (***TMJ***)

syndrome, and procedures that may have a ***cosmetic*** effect. Predetermination of benefits is recommended to help you determine your out-of-pocket expense. Also, some benefits require ***prior authorization*** as described above. Therefore, it is important that you call CIGNA HealthCare at 1-800-244-6224 for information on covered services.

Case Management

The Case Management Program assists patients requiring extensive hospitalization and/or patients that have complicated discharge-planning needs. The program identifies those patients so that coordination of services and alternative (***cost effective***) care arrangements can be made. Referral to case management screening takes place when:

- Two or more admissions within three months for the same or a related medical condition
- Two or more ***emergency*** or ***urgent care*** visits within three months for the same or related medical condition
- A ***hospital*** stay of more than 10 days
- Over $25,000 in claims year-to-date for the same or related condition

Case Management also takes place for the following medical conditions:

- Cancer
- Cerebrovascular accident (CVA)
- Chronic respiratory disease
- Congenital heart disease
- Diabetes
- Immune system deficiencies
- Infectious disease
- Ischemic heart disease
- Neonatal complications
- Neurodegenerative disorders (including multiple sclerosis, muscular dystrophy, amyotrophic lateral sclerosis)
- Organ transplant
- High-risk pregnancies
- Spinal cord ***injuries***
- Trauma

Special care arrangements, as determined by the case manager, are coordinated with the ***physician***.

Case management is a voluntary, confidential, and private process, and may involve some or all of the following activities:

- Establishing goals and care plan with the ***physician***, covered member, and/or family that may include on-site visits
- Assessing ongoing treatment at a ***hospital***, rehabilitation center, nursing home, ***hospice***, or the covered member's home
- Investigating alternative facilities and services
- Establishing home health care treatment, if appropriate
- Planning for discharge.

Case management ensures that ***medically necessary*** and appropriate services are provided to the ***covered member***. The evaluation process used in case management may reduce medically unnecessary, inappropriate, and/or harmful services, and manage costs in some cases. For more information, call CIGNA HealthCare at 1-800-244-6224.

Disease Management

The CIGNA HealthCare disease management program is known as the Well Aware Program for Better Health®. This disease management program is a voluntary program and is provided at no extra cost to members. This program helps covered members manage the following chronic conditions:

- Asthma—aims to help members prevent or lessen the severity of attacks in a variety of ways.
- Diabetes—helps members understand their condition and how it affects their overall health.
- Heart disease—helps members with coronary artery disease or congestive heart failure stay attuned to their day-to-day health and become better prepared to discuss their concerns with their ***physician***.
- Low-back pain—helps members lessen their symptoms and manage their condition.
- Chronic-obstructive pulmonary disease—helps members improve their breathing and manage their symptoms.

The covered member will receive personalized guidance and support from an experienced registered nurse. The member will receive information about his/her condition as well as reminders about important screenings and exams.

Behavioral Health Program

The Behavioral Health Program and the network of behavioral health care ***specialists*** are managed by CIGNA Behavioral Health (CBH). Coverage under this Plan provides coverage for services from in-network or out-of-network providers and facilities.

The following chart summarizes the benefits and limitations:

CIGNA Behavioral Health Program	
In-Network Option	**Out-of-Network Option**
• Out-of-pocket maximum applicable. • Must use CIGNA Behavioral Health network providers and facilities. • Plan pays 80% of eligible expenses for inpatient and outpatient services. • Unlimited outpatient visits. 90 days inpatient combined in- and out-of-network for mental health and substance abuse.	• Out-of-pocket maximum not applicable. • Use of non-CIGNA Behavioral Health network providers or facilities. • Plan pays 50% of eligible expenses for inpatient and outpatient services. • Unlimited outpatient visits. 90 days inpatient combined in- and out-of-network for mental health and substance abuse.

For assistance with the selection of an in-network behavioral health ***specialist***, contact CBH at 1-800-244-6224 or you can access the behavioral health providers listing by going to www.cignabehavioral.com as follows:

- On your Home Page, click on the "Address" entry field.
- Type www.cignabehavioral.com.
- Click on the block that says, "are you a MEMBER."
- On the left side of the following screen, click on "Find a Provider."
- On the following screen click on the "Search" button at the bottom.
- On the screen after that just enter a ZIP code in that field.
- Click on a Zip Radius — 5, 10, 15, 20, or 25.
- Enter a specialty from the drop-down menu.
- Click on the "Search" button.

On the list of providers, you may be able to click on each provider's name to view the provider's profile including demographic information, clinical practice information, and clinical practice analysis.

Medical Necessity Review and ***prior authorization*** of the behavioral health treatment (if not covered by ***Medicare***) is required in order to qualify for the maximum available benefits under this Plan. The Medical Necessity Review determines if the treatment plan will meet your needs and whether treatment is ***medically necessary*** under the terms of this Plan. The Medical Necessity Review is conducted by CBH and the behavioral health care ***specialist*** you have selected.

In the case of ***inpatient*** and/or ***emergency*** services, the behavioral health care practitioner, the ***emergency*** service, a friend, or family member must notify CBH (call 1-800-244-6224 and ask for CBH) within two working days of admission or as soon as reasonably possible. If ***inpatient*** or ***emergency*** services occur after business hours, on a holiday, or on a weekend, voice message is available, and a call will be returned the next business day.

If the ***hospital*** is not in the network, in-network benefits will be paid until the patient is stabilized. Once stabilized, the patient must be moved to a network ***hospital*** to continue coverage under the in-network level of benefits.

Non-Emergency or Non-Urgent Care When Away from Home

If you are not experiencing an ***emergency*** or ***urgent care*** situation, please call CIGNA HealthCare at 1-800-244-6224 to obtain information on in-network providers located in the area you will be visiting.

CIGNA LIFESOURCE Transplant Network

CIGNA HealthCare LIFESOURCE is a network of participating organ and tissue transplant centers that have been evaluated for favorable rates of patient outcomes, as well as waiting periods, housing arrangements, and "patient friendly" environments. Members in the LIFESOURCE Transplant Network are managed by the Comprehensive Transplant case management unit. This unit consists of registered nurses with clinical experience in transplant, hematology/oncology, home health care, dialysis, critical care, and/or community care. They are specially trained to manage complex transplant cases.

In some instances, a travel allowance is offered as a feature of the program. Be aware that most of the travel allowance is usually considered taxable income.

Prescription Drug Program

The prescription drug program available to covered members is through CIGNA HealthCare participating pharmacies for retail drugs and through CIGNA Tel-Drug for mail-order prescription drugs.

As a covered member in this CIGNA Senior Premier PPO, you are provided a three-tiered prescription drug benefit at retail stores and an in-network benefit for mail-order prescription drugs.

Medicare Part D

If you enroll in the CIGNA Senior Premier PPO Plan, you do not need to enroll in ***Medicare*** Part D. In essence, no action is required on your part with respect to ***Medicare*** Part D when you are a member of this Plan.

If you enroll in one of the ***Medicare*** prescription drug plans on your own, the prescription drug coverage under this CIGNA Senior Premier PPO Plan is not available to you and you will be dropped from prescription drug coverage under this Plan.

> **Note:** If you enroll in a ***Medicare*** prescription drug program on your own, the Lovelace Senior Plan (LSP) through Sandia will disenroll you entirely from the LSP.

We cannot tell you not to enroll in one of the ***Medicare*** prescription drug plans; but you should know that the plans offered through Sandia are at least as good if not better than ***Medicare's*** prescription drug coverage. You should have received a "Notice of Creditable Coverage" from Sandia which states this information for the self-insured CIGNA Senior Premier PPO Plan. The ***Medicare*** Advantage health plans (Lovelace Senior Plan and Presbyterian ***Medicare*** PPO) are automatically creditable coverage by virtue of the fact that they qualify as ***Medicare*** health plans and they are not required to send you a notice of creditable coverage. Sandia is required to give you this notice for the self-insured plans annually (which will be during Open Enrollment each year) so that you know whether the coverage is at least as good as ***Medicare's*** coverage. If for some reason you want to drop our coverage or you lose the coverage, you will be able to enroll in a ***Medicare*** prescription drug plan without incurring a penalty.

There may be some situations where you may be better off getting the ***Medicare*** benefit, such as if you qualify for the low-income subsidy or if you are in a skilled nursing facility, etc. Contact ***Medicare*** if you have any questions on what you may qualify for under the ***Medicare*** Part D benefit.

If you have questions about the ***Medicare*** benefit, contact ***Medicare*** at www.medicare.gov or call 1-800-633-4223.

Prescription Drug List

For a listing of the CIGNA HealthCare Preferred Drug List, visit www.mycigna.com or call the number on the back of your CIGNA HealthCare ***ID*** card.

Prescription drugs are covered at the ***coinsurance*** amount (with minimum and maximum charges for a 30-day prescription) for retail and at a defined ***copay*** amount (for a 90-day prescription) for mail order as shown in the following table.

Three-Tier Prescription Drug Plan

The following table describes the three-tier prescription drug plan for generic, preferred brand name, and non-preferred brand name. The minimum and maximum amounts are subject to change and are communicated during the Open Enrollment period Sandia holds each fall:

	Prescription	In-Network	Out-of-Network
Tier	**Retail (30-day supply prescription)**		
1	Generic	20% of retail $6 minimum and $12 maximum	50% of retail less applicable minimum copay
2	Brand Name (preferred)	30% of retail $25 minimum and $40 maximum	50% of retail less applicable minimum copay
3	Brand Name (non-preferred)	40% of retail $40 minimum and $60 maximum	50% of retail less applicable minimum copay
Tier	**Mail Order (90-day supply prescription)**		
1	Generic	$18 copay	N/A
2	Brand Name (preferred)	$65 copay	N/A
3	Brand Name (non-preferred)	$100 copay	N/A

To get your prescription filled, simply

- Take your prescription to any CIGNA HealthCare participating pharmacy
- Present your CIGNA HealthCare ***ID*** card
- Pay your ***coinsurance*** amount.

Participating pharmacies include major chains as well as local drug stores. Check your directory at www.cigna.com or call the number on your CIGNA HealthCare ***ID*** card.

Savings Through Mail Order

You may want to take advantage of the savings available through mail-order prescription drugs for your maintenance drugs for conditions such as arthritis, high blood pressure, asthma, diabetes, or endocrine/metabolic conditions. An example of savings is when you

order a three-month supply of generic medication for $18 instead of paying $36 at a retail store for three separate prescriptions.

To start your mail-order prescriptions, ask you ***physician*** to give you two prescriptions—one 30-day prescription and a separate prescription for the year to get your prescription through mail order. You may get a mail-order form by calling Sandia ***HBES*** at (505) 844-4237 or on the web by registering for access to www.mycigna.com.

To switch to the convenience of mail-order prescription drugs, call CIGNA Tel-Drug at 1-800-835-3784, choose option 1 and mention extension 501. Provide your prescription medication information as well as the prescribing doctor's name and phone number. Tel-Drug will handle your switch to mail order for you—there is no paperwork.

CIGNA HealthCare members who register for access to www.mycigna.com can order refills and can access their prescription order history on the web.

The CIGNA mail-order program is through Tel-Drug at 1-800-835-3784 or www.teldrug.com or mail to: CIGNA Tel-Drug, P.O. Box 1019, Horsham, PA 19044-9805.

Provider Networks

Network availability depends on the ability of CIGNA HealthCare to contract with providers. CIGNA HealthCare has contracted with providers across the country.

Sandia, through CIGNA HealthCare, strives to make available to the covered member quality health care service by way of the credentialing process. Even though Sandia strives to provide you with quality medical services, neither Sandia nor its plans can guarantee quality of care. Employees always have the choice of what services they receive and who provides their health care regardless of what the Plan covers or pays.

The network provider, specialty care ***physicians***, ***hospitals***, and other health care provider/facilities participating in the network are contracted by CIGNA HealthCare and CBH.

In some cases, CIGNA HealthCare has established direct contracts with individual provider. The ***participating providers*** work with CIGNA HealthCare to organize an effective and efficient health care delivery system. Outside the greater Albuquerque area, CIGNA HealthCare has contracted with providers offering in-network care.

Note: Your ***physician*** may contact CIGNA HealthCare at www.cigna.com to request membership in any of these networks.

The most current provider directory of in-network providers can be found on www.mycigna.com. Register first to access this valuable tool.

Provider Directories

The CIGNA HealthCare directory lists of providers and auxiliary services are available online. You can select your ***physician*** from family care ***physicians***, internists, pediatricians, and other ***specialists*** who have contracted to participate in the CIGNA HealthCare Open Access Plus network.

Specialty care and ***hospital*** services generally are provided by the ***hospital*** with which the ***physicians*** or ***specialists*** you select are affiliated.

Provider directories will be furnished by CIGNA HealthCare or may be obtained online as described below. Directories are current as of the date they are printed. The provider networks change often. For the most current information, contact CIGNA HealthCare at 1-800-244-6224 or, without registering, access the web information at www.cigna.com. The Open Access Plus option should be selected as the network type.

Online Directories

The most up-to-date directories are available online and are updated every two weeks. Register at www.mycigna.com to access your personalized medical care information. The system will know in which plan you are enrolled.

When You Schedule An Appointment

When you call the provider's office to make an appointment, identify yourself as a member of the CIGNA Senior Premier PPO Plan (Open Access Plus). When you check in for your appointment, use your CIGNA HealthCare ***ID*** card to identify your plan coverage and to facilitate the processing of your claim.

Note: Failure to present the covered member's ***ID*** card may result in incorrect billing and claim payment delay.

Canceling Your Appointment

If you cannot keep your appointment, be courteous to other members and to your provider by calling to cancel your appointment. The time you leave open is needed by someone else to receive medical care. Any charge for missed appointments will not be covered by this Plan.

Transferring Your Medical Records

If you want previous medical records transferred to your ***physician's*** office, ask the office receptionist for instructions, or ask your former ***physician*** to transfer your records.

When You Change Your Address

When you move, change your address in the Sandia database. Notify Sandia Benefits, as soon as possible, about any changes in family size, address, phone number, and coverage status at the following address or phone number.

New Mexico:
Benefits
Department 3332, MS 1022
P.O. Box 5800
Albuquerque, NM 87185
or by Phone: (505) 844-4237

California:
Personnel & Employee Resources
Department 8522, MS 9111
P.O. Box 969
Livermore, CA 94551-9111
or by Phone: (925) 294-2254

Note: You must disenroll or enroll your dependents in this Plan within 31 calendar days of the effective date of change in ineligibility or eligibility for coverage under this Plan. Contact Sandia ***HBES*** at (505) 844-4237 for more information.

Section 9. Resources to Help You Stay Healthy

This section provides resources that are available to you as a member of the CIGNA Senior Premier ***PPO***.

CIGNA HealthCare brings a comprehensive medical program to cover you and your family's needs. It is CIGNA HealthCare's goal to provide covered members with information to help you manage medical conditions and resources and tools to help members become educated health care consumers.

> **Note:** To get your personalized information, go online at www.mycigna.com and click on "Register Now!" You will be asked for your date of birth, ZIP code, and member ***ID*** to register.

www.mycigna.com

Covered member of the CIGNA Senior Premier ***PPO*** Plan may register online at www.mycigna.com to access the following information and tools.

- **Plan Benefits**—view claim status, view and print an ***EOB***, order ***ID*** cards or print a temporary one, locate contracted providers, learn about plan benefits and features, and get answers to frequently asked questions.
- **Health Quotient**—fill out a brief health risk assessment questionnaire that will provide members with a health profile and provide recommendations to help enhance health and well-being.
- **Health Record**—enter medications, allergies, surgeries, immunizations, and ***emergency*** contacts in a central, secure location.
- **Health Tracker**—input data such as blood pressure, blood sugar, cholesterol, height, weight, and exercise; the program charts your results so you can share them with your doctor.
- **Quality Care Tool**—access information on how ***hospitals*** rank by number of procedures performed, patients' average length of stay, and cost.
- **Locate a Network Provider**—find the most up-to-date information on contracted providers, ***hospitals***, and facilities closest to home and work. The website is updated every two weeks.

CIGNA HealthCare offers the following special programs for members' health care needs:

- **CIGNA LIFESOURCE Transplant Network**[SM] includes over 50 leading transplant facilities. CIGNA HealthCare offers personalized case management and a travel allowance.

- **CIGNA HealthCare 24-Hour Health Information Line**[SM]—assistance from a registered nurse, seven days a week, 24-hours a day. The nurse can provide detailed answers to your health questions, provide helpful home care suggestions, assist in choosing the most appropriate care and assist in locating a contracted provider if you are out of your ***service area***.
- **The Health Information Line** also provides access to hundreds of health topics through a library of audio tapes. The programs are updated regularly and are based on current medical research and treatments. You can listen to as many programs as you like; 24-hours a day, seven days a week.

  The Health Information Line is available by calling 1-800-564-9286.
- **Well-Aware – Disease Management Program**—helps in managing chronic conditions. Through the Well-Aware program, members can receive support with chronic conditions such as asthma, diabetes, health disease, low-back pain, and chronic obstructive pulmonary disease. Each program is personalized and offers a wide selection of tools. For more information, call 1-877-888-3091.

Section 10. Medicare and How Coverage is Coordinated with the CIGNA Senior Premier PPO Plan

This section outlines some basic information about ***Medicare*** Parts A and B and how coverage under ***Medicare*** and this Plan is coordinated. In most cases, this Plan will be your secondary coverage when you become eligible for ***Medicare primary*** coverage.

IMPORTANT

*To get maximum benefits under **COB**, you should enroll for both **Medicare** Parts A and B when you become Medicare primary. Claims will be paid as though you are enrolled in both **Medicare** Parts A and B.*

What is Medicare?

Medicare administered by the Social Security Administration, is the U.S. federal government health insurance program for:

- People age 65 or older
- People under age 65 with certain disabilities and
- People of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant)

Medicare benefits are provided regardless of income level.

Health coverage under ***Medicare*** includes Parts A, B, and D. The following highlights the ***Medicare*** Parts A, B, and D and the coverage ***Medicare*** provides under each part.

Medicare **Part A** (***Hospital*** Insurance Plan) covers:

- ***Hospital*** benefits
- ***Hospice*** care
- Home health services
- Skilled nursing facility care (does not include nursing homes)

Persons age 65 and over who have enough quarters of coverage to receive Social Security whether retired or still working (and spouses of those persons who are age 65 or over) receive Part A coverage at no cost.

Persons age 65 and older who continue to work at Sandia and are covered by an active employee medical plan such as the CIGNA Premier PPO Plan continue to get primary coverage under that plan.

Persons no longer employed (e.g., retired) and age 65 or older shall have ***Medicare*** provide primary health coverage. Any person who elects to continue coverage under this Plan will have this Plan as secondary coverage after ***Medicare***.

If you are not eligible for free ***Medicare*** Part A coverage, you may enroll by paying the full premium to ***Medicare***.

For purposes of coverage under this Plan, you will be considered as if you are enrolled in ***Medicare*** Part A. Claims under this Plan will be paid as though you are enrolled in Part A.

Medicare **Part B** (Medical Insurance Plan) covers a portion of the following types of charges after an annual ***Medicare deductible*** is met:

- ***Physician*** services
- Medical services
- ***Outpatient*** diagnostic or treatment services

Persons eligible for ***Medicare*** Part A can purchase Part B by paying a monthly ***Medicare*** premium. The payment is normally deducted from the Social Security benefit.

For purposes of coverage under this Plan, you will be considered as if you are enrolled in ***Medicare*** Part B. Claims under this Plan will be paid as though you are enrolled in Part B.

Medicare **Part D** (Prescription Drug Insurance Plan) covers a portion of your prescription drug costs.

Persons eligible for ***Medicare*** Parts A or B can purchase Part D. The Part D prescription drug plan under ***Medicare*** is voluntary.

For purposes of coverage under this Plan, Sandia will be taking the government subsidy for your prescription drug. If you elect ***Medicare*** Part D coverage then you are not eligible for the Sandia-sponsored prescription drug program under this Plan.

Medicare Eligible and Medicare Primary

Medicare eligible means that a person:

- Reached age 65 or

- Receiving Social Security benefits for two years, or
- Has end-stage renal disease

Eligibility is independent of whether you continue to work, when you begin to draw Social Security benefits, or whether you enroll for ***Medicare*** benefits.

Medicare primary means that a person is ***Medicare eligible*** and:

- Not an active employee (unless you have end-stage renal disease)
- Covered as a dependent of an active employee and the dependent has end-stage renal disease or is ***Medicare eligible*** due to disability
- Eligible to enroll in ***Medicare*** and not a Sandia employee

Medicare primary coverage means that when medical claims are filed, the claims are filed first (primary coverage) with ***Medicare***, and then, after consideration by ***Medicare***, claims are filed (secondary coverage) with CIGNA HealthCare for coverage under this Plan.

CIGNA HealthCare has an interface with ***Medicare*** where ***Medicare*** will submit your claims directly to CIGNA HealthCare for coverage consideration.

IMPORTANT

Class II dependents *who are* ***Medicare eligible*** *are always* ***Medicare primary****, even if covered under an active employee.*

Enrolling in Medicare

Part A Enrollment

In general, you will automatically get ***Medicare*** Part A if you are already getting benefits from Social Security, starting the first day of the month you turn age 65, or if you are under age 65 and disabled and have received disability benefits from Social Security for 24 months.

If you aren't automatically enrolled in ***Medicare*** Part A and you are eligible for ***Medicare***, call the Social Security Administration at 1-800-772-1213 or visit www.medicare.gov for more information.

Most people don't have to pay for ***Medicare*** Part A, if they or their spouse worked 10 or more years in ***Medicare***-covered employment.

Part B Enrollment

Enrolling in Part B is your choice. If you are close to age 65 and you do not currently receive Social Security or Railroad Retirement benefits, or ***Medicare*** Part A, you can sign up for ***Medicare*** Part B when you apply for retirement benefits or ***Medicare*** Part A.

If you aren't automatically enrolled in ***Medicare*** Part B, contact the Social Security Administration at 1-800-772-1213 or visit www.socialsecurity.gov.

The following are the opportunities for you to enroll in ***Medicare*** Part B, if you are eligible for ***Medicare***.

1. **Initial Enrollment Period** is a seven-month period that begins three months before the month you are first eligible for ***Medicare*** Part B (usually three months before the month you reach age 65. It ends three months after you reach age 65.

2. **General Enrollment Period,** runs from January 1 through March 31 of each year. ***Medicare*** coverage will start on July 1 of the year you sign up.

   The cost of ***Medicare*** Part B goes up 10 percent for each full 12-month period that you could have taken ***Medicare*** Part B (for special-case exceptions contact your Social Security office).

3. **Special Enrollment Period** is available if you are eligible for ***Medicare*** based on age 65 or disability, but you waited to enroll in ***Medicare*** Part B because you or your spouse were working and you had employer group health coverage as your primary coverage.

   If this applies to you, you are eligible to sign up for ***Medicare*** Part B any time while you are covered by the employer group health plan based on current employment status or during the eight-month period following the month the group health plan coverage ends or the employment ends, whichever is first.

   The Special Enrollment Period allows you to enroll in ***Medicare*** Part B without having to pay the additional 10% premium for each full 12-month period that you delayed enrollment in ***Medicare*** Part B.

For the most up-to-date information about signing up for ***Medicare*** Part A and Part B, contact the Social Security Administration at 1-800-772-1213 or your local Social Security office, or you may find information on the web at www.medicare.gov.

Employer Group Medical Plan as Primary Coverage for Medicare-Eligible Member

There are certain situations where a Sandia-sponsored medical plan may continue to provide primary coverage to persons that are ***Medicare eligible***.

1. **Active Employee at Sandia**—If you continue to be actively employed at Sandia and you do not have end-stage renal disease, you are not considered eligible for ***Medicare primary*** coverage and you are not eligible for this Plan. Refer to the CIGNA Premier PPO Plan for eligibility in that Plan.

2. **Retiree or *long-term disability terminee* and you are a *c*overed dependent of an active employee at Sandia**—If you are a covered dependent of your spouse who is actively employed at Sandia and you do not have end-stage renal disease, you are not considered eligible for ***Medicare primary*** coverage and you are not eligible for this Plan. Refer to the CIGNA Premier PPO Plan for eligibility for that Plan.

Refer to the ***Medicare*** booklets *Medicare & You* and *Enrolling in Medicare* for more information. You can access the booklets from ***Medicare*** at www.medicare.gov or 1-800-633-4227, or by calling your local Social Security office.

Plan Features and Requirements for Medicare Primary Members

You should be enrolled in both ***Medicare*** Parts A and B in order to maximize your health care coverage. This Plan is your secondary medical coverage and claims will be paid as though you are enrolled in both ***Medicare*** Parts A and B. This Plan will estimate what ***Medicare*** would have paid and will pay only the appropriate secondary portion.

You are subject to a lifetime maximum for medical coverage under this Plan. The lifetime maximum is $150,000 for the employer-paid portion of in-network and out-of-network claims combined. The first $3,500 of benefits paid each calendar year is not applied to the $150,000 lifetime maximum. The Prescription Drug Program benefits paid do not apply to the ***deductibles*** or the lifetime maximum.

Physicians and Medicare Assignment

You should discuss assignment issues with your doctor to determine upfront, out-of-pocket expenses that you will have to pay.

Assignment is an arrangement whereby some ***physicians*** agree to accept the ***Medicare***-approved (allowable) amount as full payment for services covered under ***Medicare*** Part B and writes off any amount above the ***Medicare*** allowable amount. ***Medicare*** usually reimburses 80% of the allowable assigned fee directly to the ***physician***, and the ***physician*** then bills the patient (or the claims administrator) for the remainder up to but not over the approved amount.

However, if your doctor does not accept ***Medicare*** assignment, but is a ***Medicare*** participating provider, this means that the ***physician*** has not agreed to accept the ***Medicare***-

allowed amount as full payment. In this case, the patient is liable for the amounts above the ***Medicare*** allowable fee up to the ***Medicare*** limiting fee, which 115% of the ***Medicare*** allowed amount. Because ***Medicare*** pays its share of the bill to you and not to the doctor when a claim is unassigned, the doctor could ask you to pay at the time of your visit.

Even if your doctor does not accept ***Medicare*** assignment, your doctor is required to file with ***Medicare***, and ***Medicare*** will pay you directly. ***Medicare*** will also file your claim with CIGNA HealthCare—attaching the ***Medicare Explanation of Benefits*** (***EOB***). CIGNA HealthCare will then reimburse you the difference between the ***Medicare*** share of the CIGNA HealthCare's ***negotiated fees*** if you are using the in-network PPO option.

If you are using the out-of-network, non-PPO option, you will be reimbursed the difference between the ***Medicare*** share of the CIGNA HealthCare's ***usual and customary charges*** (***U&C***) charges for your geographic area. Any amount billed above the ***U&C*** charges is your responsibility.

If you choose to seek medical care from a ***physician***, ***hospital***, or supplier that is a non-***Medicare*** approved provider, the CIGNA HealthCare will estimate ***Medicare's*** benefit and you will be responsible for what ***Medicare*** would have paid for coverage for both ***Medicare*** Parts A and B.

Coordination of Coverage with Medicare

Sandia interfaces with ***Medicare*** to eliminate duplicate payments and to provide a sequence in which coverage applies when an individual is ***Medicare primary*** and elects to continue coverage under this Plan. With some exceptions, ***Medicare*** will provide your primary health care coverage. The CIGNA Senior Premier PPO Plan will provide secondary coverage for eligible ***covered health services***.

IMPORTANT

*To get maximum benefits under **COB**, you should enroll in both **Medicare** Parts A and B. Claims will be paid as though you are enrolled in both **Medicare** Parts A and B.*

Policy

All benefits under this Plan are subject to coordination with the benefits of other health care plans including ***Medicare*** if medical expenses are considered covered expenses under this Plan. Covered expense means any expense that is covered by at least one plan during a claim period; however, any expense that is not payable by the ***primary plan*** because of the covered member's failure to comply with the cost containment requirements (e.g., second surgical opinions, pre-admission testing, pre-admission review of ***hospital confinement***, mandatory ***outpatient surgery***, etc.) will not be considered a covered expense, and, therefore, is not paid under this Plan.

Note: If your other health care coverage, including ***Medicare***, does not cover a health service that is covered under this Plan, this Plan will provide primary coverage for said covered health service.

Coordination of Coverage

The following table presents a number of scenarios on how the sequence of coverage applies.

	If you…	Primary Payer is…	Secondary Payer is…	Last Payer is…
1	continue to work as an active employee at Sandia after age 65	this Plan		
2	retire from Sandia and enroll for benefits at your new job and do not enroll in Medicare	your new employer group plan	this Plan	
3	retire from Sandia, enroll for benefits at your new job, are over age 65, and enroll in Medicare	your new employer group plan	Medicare	this Plan
4	are age 65 and are the enrolled dependent of an employee who continues to work at Sandia after age 65 and you enroll in Medicare	this Plan	Medicare	any other coverage you have
5	are age 65 and are the enrolled dependent of an employee who works somewhere other than Sandia after age 65 and you enroll in Medicare	spouse's plan	Medicare	any other coverage you have
6	(or your covered spouse or dependent) are age 65 or over or have been receiving Social Security disability benefits for at least 24 months, and you are eligible for Medicare	Medicare	this Plan	
7	have permanent kidney failure and are not covered by another employer's plan as an employee or dependent, and you are eligible for Medicare	Medicare	this Plan	
8	are under age 65, have been receiving disability benefits for at least 24 months, are a dependent of a working spouse, and you are eligible for and enrolled in Medicare	spouse's plan	Medicare	this Plan

	If you…	Primary Payer is…	Secondary Payer is…	Last Payer is…
9	are age 65 or older; no longer an eligible dependent of a Sandia employee or retiree; eligible for Medicare, elect COBRA continuation of coverage, and have no other health care coverage	Medicare	this Plan	

When this Plan becomes your secondary payer, your claims should be filed as follows:

- You or your ***physician*** file your claims with ***Medicare*** first (primary payer);
- After ***Medicare*** considers your claims and responds with an ***EOB***, you or your ***physician*** file the claims with CIGNA HealthCare and attach a copy of the ***Medicare EOB*** to your claim.
    - CIGNA HealthCare will then process your claims and make claim payment as if you are enrolled in both ***Medicare*** Parts A and B.

Examples of Coordination of Benefits with Medicare

The following examples show how ***COB*** under this Plan is handled along with ***Medicare's*** coverage. This Plan interfaces with ***Medicare*** to eliminate duplication of payments for services.

The following examples:

- assume that the providers accept ***Medicare*** assignment; therefore, any amounts above ***Medicare's*** allowable are written off by the service provider.
- are based on the ***Medicare*** deductibles for 2006, which are $124 for Part B and $942 for Part A.
- are rounded to whole dollar amounts for purposes of ease of explanation.

In-Network Examples

1st claim of the year—Specialist Office Visit

***Medicare* consideration of this claim:**

Total Charge	**$210**
Less Provider Write-Off	$10
Equals Medicare Allowable	**$200**
Medicare Annual Deductible	$124
Balance After Deductible	$76
Medicare Coverage at 80% After Deductible	$61
Balance Due by member **without** COB	**$139**

- ***Medicare*** Part B ***deductible*** is $124 for calendar year 2006. Balance Due is $124 (deductible) + $15 (20% of $76) = $139.

CIGNA Senior Premier PPO consideration:

Medicare Allowable	**$200**
Plan Coverage at 80% of Medicare Allowable	$160
Less Medicare Coverage 80% After Deductible	$61
Equals CIGNA Payment	$99
Balance Due by member (20%) **with** COB with CIGNA Senior Premier PPO Coverage	**$40**

- Balance Due is $40 (20% of $200). The $40 you pay is applied towards your annual ***out-of-pocket maximum*** of $1,000—Balance: $960.

2nd claim of the year—ER Visit to In-Network Facility

***Medicare* consideration of this claim:**

Total Charge	**$600**
Less Provider Write-Off	$150
Equals Medicare Allowable	**$450**
Medicare Annual Deductible	$0
Balance After Deductible	$450
Medicare Coverage 80% After Deductible	$360
Balance Due by member (20%) **without** COB	**$90**

- ***Medicare*** Part B ***deductible*** of $124 was met with the first claim submitted.

CIGNA Senior Premier PPO consideration:

Medicare Allowable	**$450**
Plan Coverage 80% of Medicare Allowable	$360
Less Medicare Coverage 80% After Deductible	$360
Equals CIGNA Payment	$0
Balance Due by member (20%) **with** COB with CIGNA Senior Premier PPO Coverage	**$90**

- The $90 you pay is applied towards your ***out-of-pocket maximum*** of $1,000—Balance: $960 - $90 = $870.

3rd claim of the year—Ambulance

***Medicare* consideration of this claim:**

Total Charge	**$395**
Less Provider Write-Off	$70
Equals Medicare Allowable	**$325**
Medicare Annual Deductible	$0
Balance After Deductible	$325
Less Medicare Coverage 80% After Deductible	$260
Balance Due by member **without** COB	**$65**

- ***Medicare*** Part B ***deductible*** of $124 has been met for the calendar year.

CIGNA Senior Premier PPO consideration:

Medicare Allowable	**$325**
Plan Coverage 80% of Medicare Allowable	$260
Less Medicare Coverage 80% After Deductible	$260
Equals CIGNA Payment	$0
Balance Due by member (20%) **with** COB with CIGNA Senior Premier PPO COB	**$65**

- The $65 you pay is applied towards your ***out-of-pocket maximum*** of $1,000—Balance: $870 - $65 = $805.

4th claim of the year—Outpatient Surgeon Charge

***Medicare* consideration of this claim:**

Total Charge	**$2,200**
Less Provider Write-Off	$200
Equals Medicare Allowable	$2,000
Medicare Annual Deductible	$0
Balance After Deductible	$2,000
Less Medicare Coverage 80% After Deductible	$1,600
Balance Due by member **without** COB	**$400**

- ***Medicare*** Part B ***deductible*** of $124 has been met for the calendar year.

CIGNA Senior Premier PPO consideration:

Medicare Allowable	**$2,000**
Plan Coverage 80% of Medicare Allowable	$1,600
Less Medicare Coverage 80% After Deductible	$1,600
Equals CIGNA Payment	$0
Balance Due by member (20%) **with** COB with CIGNA Senior Premier PPO Coverage	**$400**

- The $400 you pay is applied towards your ***out-of-pocket maximum*** of $1,000—Balance: $805 - $400 = $405.

5th claim of the year—Preventive Physical Exam

***Medicare* consideration of this claim:**

Total Charge	**$230**
Less Provider Write-Off	$20
Equals Medicare Allowable	**$210**
Medicare Annual Deductible	$0
Balance After Deductible	$210
Medicare Coverage 0% After Deductible	$0
Balance Due by member **without** COB	**$210**

- ***Medicare*** Part B ***deductible*** of $124 has been met for the calendar year.

CIGNA Senior Premier *PPO* consideration:

Medicare Allowable	**$210**
Plan Coverage 100% of Medicare Allowable	$210
Less Medicare Coverage 0% After Deductible	$0
Equals CIGNA Payment	$210
Balance Due by member with COB with CIGNA Senior Premier PPO Coverage	**$0**

- There are no ***out-of-pocket maximum*** costs for this service; therefore your ***out-of-pocket maximum*** of $1,000—Balance: $405 - $0 = $405.

6th claim of the year—Inpatient Hospital Stay Facility

***Medicare* consideration of this claim:**

Total Charge	**$10,500**
Less Provider Write-Off	$0
Equals Medicare Allowable	$10,500
Medicare Annual Deductible	$952
Balance After Deductible	$9,548
Medicare Coverage 100% After Deductible	$9,548
Balance Due by member **without** COB	**$952**

- ***Medicare*** Part A ***deductible*** is $952 for calendar year 2006.

CIGNA Senior Premier *PPO* consideration:

Medicare Allowable	**$10,500**
Plan Coverage 80% of Medicare Allowable	$8,400
Less Medicare Coverage 100% After Deductible	$9,548
Balance Due (deductible)	**$952**
Balance Due by member with COB with CIGNA Senior Premier PPO Coverage	**$405**
Plan Coverage Amount Above Out-of-Pocket Maximum	**$547**

- The $405 you pay is applied towards your ***out-of-pocket maximum*** of $1,000—Balance: $405 - $405 = $0. Therefore, this Plan pays any amount over your $1,000 ***out-of-pocket maximum*** which was $547.
- This Plan will continue to pay any eligible expense over your ***out-of-pocket maximum*** for the remainder of the calendar year.

Out-of-Network Examples

1st claim of the year—Specialist Office Visit

***Medicare* consideration of this claim:**

Total Charge	**$210**
Less Provider Write-Off	$10
Equals Medicare Allowable	$200
Medicare Part B Annual Deductible	$124
Balance After Deductible	$76
Medicare Coverage 80% After Deductible	$61
Balance Due by member **without** COB	**$139**

- ***Medicare*** Part B ***deductible*** is $124 for calendar year 2006.

CIGNA Senior Premier *PPO* consideration:

Medicare Allowable	**$200**
Plan Coverage 80% of Medicare Allowable	$160
Less Medicare Coverage 80% After Deductible	$61
Equals CIGNA Payment	$99
Balance Due by member (20%) with COB **with** CIGNA Senior Premier PPO Coverage	**$40**

- Balance Due is $40 (20% of $200). The $40 you pay is applied towards your annual ***out-of-pocket maximum*** of $1,000—Balance: $960.

2nd claim of the year— MRI at Out-of-Network Facility

***Medicare* consideration of this claim:**

Total Charge	**$1,300**
Less Provider Write-Off	$100
Equals Medicare Allowable	$1,200
Medicare Annual Deductible	$0
Balance After Deductible	$1,200
Medicare Coverage 80% After Deductible	$960
Balance Due by member **without** COB	**$240**

- ***Medicare*** Part B ***deductible*** of $124 has been met with the first claim submitted.

CIGNA Senior Premier PPO consideration:

Medicare Allowable	**$1,200**
Plan Coverage 80% of Medicare Allowable	$960
Less Medicare Coverage 80% After Deductible	$960
Equals CIGNA Payment	$0
Balance Due by member (20%) with COB with CIGNA Senior Premier PPO Coverage	**$240**

- The $240 you pay is applied towards your ***out-of-pocket maximum*** of $1,000—Balance: $960 - $240 = $720.

3rd claim of the year—Ambulance

***Medicare* consideration of this claim:**

Total Charge	**$495**
Less Provider Write-Off	$170
Equals Medicare Allowable	$325
Medicare Annual Deductible	$0
Balance After Deductible	$325
Medicare Coverage 80% After Deductible	$260
Balance Due by member **without** COB	**$65**

- ***Medicare*** Part B ***deductible*** of $124 has been met for calendar year 2006.

CIGNA Senior Premier *PPO* consideration:

Medicare Allowable	**$325**
Plan Coverage 80% of Medicare Allowable	$260
Less Medicare Coverage 80% After Deductible	$260
Equals CIGNA Payment	$0
Balance Due by member (20%) **with** COB **with** CIGNA Senior Premier PPO Coverage	**$65**

- The $65 you pay is applied to your ***out-of-pocket maximum*** of $1,000—Balance: $720 - $65 = $655.

4th claim of the year— Routine Physical Charge

***Medicare* consideration of this claim:**

Total Charge	**$210**
Less Provider Write-Off	$10
Equals Medicare Allowable	$200
Medicare Annual Deductible	$0
Balance After Deductible	$200
Medicare Coverage (0%) After Deductible	$0
Balance Due by member **without** COB	**$200**

- ***Medicare*** Part B ***deductible*** of $124 has been met for calendar year 2006.

CIGNA Senior Premier *PPO* consideration:

Medicare Allowable	**$200**
Plan Coverage 80% of Medicare Allowable	$160
Less Medicare Coverage (0%) After Deductible	$0
Equals CIGNA Payment	$160
Balance Due by member (20%) **with** COB with CIGNA Senior Premier PPO Coverage	**$40**

- The $40 you pay is applied to your ***out-of-pocket maximum*** of $1,000—Balance: $655 - $40 = $615.

5th claim of the year—Outpatient Surgeon Charge

***Medicare* consideration of this claim:**

Total Charge	**$6,200**
Less Provider Write-Off	$2,200
Equals Medicare Allowable	$4,000
Medicare Annual Deductible	$0
Medicare Coverage 80% After Deductible	$3,200
Balance Due by member **without** COB	**$800**

- ***Medicare*** Part B ***deductible*** of $124 has been met for calendar year 2006.

CIGNA Senior Premier *PPO* consideration:

Medicare Allowable	**$4,000**
Plan Coverage 80% of Medicare Allowable	$3,200
Less Medicare Coverage 80% After Deductible	$3,200
Balance Due	$800
Balance Due by member **with** COB with CIGNA Senior Premier PPO Coverage	**$615**
Plan Coverage Amount Above OOP Maximum	**$185**

- The $615 you pay is applied towards your ***out-of-pocket maximum*** of $1,000—Balance: $615 - $615 = $0. Therefore this Plan pays any amount over your $1,000 ***out-of-pocket maximum***, which was $185.
- This Plan will continue to pay any eligible expense over your ***out-of-pocket maximum*** for the remainder of the calendar year.

Subrogation and Reimbursement Rights

Subrogation means the Plan's or claims administrator's (CIGNA HealthCare) right to recover any Plan payments made because of an ***illness*** or ***injury*** to you or your covered dependent when the ***illness*** or ***injury*** was caused by a third party's wrongful act or negligence and for which you or your covered dependent have a right of action or later recover said payments from the third party.

If you or your covered dependent requires medical treatment because of a third party's wrongful act or negligence, the claims administrator, CIGNA HealthCare, will authorize payment of Plan benefits pursuant to the terms of the Plan. As a Plan participant, you and your dependents acknowledge and agree as follows:

- The Plan and/or CIGNA HealthCare is subrogated to any recovery from or right of action against that third party (agree to pay Sandia back if third party pays you).
- You and/or your covered dependent will not take any action that would prejudice the Plan's ***subrogation*** rights (will not impede the Plan's recovery actions).
- You and/or your covered dependent will cooperate in doing what is reasonably necessary to assist in any recovery, including seeking recovery of medical expenses as an element of damages in any action you bring as a result of the activity resulting in the ***illness*** or ***injury*** (will assist the Plan directly or indirectly to recover payments).
- You and/or your covered dependent shall reimburse CIGNA HealthCare from any money recovered from the third party for any ***injury*** or treatment or condition for which the CIGNA HealthCare provided benefit.
- CIGNA HealthCare will recover payments only to the extent that Plan benefits paid for treatment were provided as a result of the ***injury*** or condition giving rise to the claim.

Sandia will be subrogated only to the extent of Plan benefits paid for that ***illness*** or ***injury***.

Failure to comply with the Plan's ***subrogation*** rules may result in termination of coverage for cause as well as legal action by the Plan to recover benefits paid that would otherwise have been subject to recovery under the Plan's reimbursement/***subrogation*** rights.

Note: If the injured party is a minor dependent, the primary covered member must perform the above agreements and/or duties.

Section 11. Claims and Appeals

This section provides an overview of benefits payments, right to recovery of excess payment, and your claim denials and appeals procedures.

In performing its obligation to process and adjudicate claims for plan benefits, CIGNA HealthCare is the claims fiduciary. As such, CIGNA HealthCare has the sole authority and discretion to determine whether submitted claims are eligible for benefits and to interpret, construe, and apply the provisions of the Plan (with the exception of member eligibility provisions which, except for incapacitated dependent status, are determined by Sandia) in processing and adjudicating claims, including appeals. CIGNA HealthCare's determination is conclusive and not subject to review by Sandia. Upon written request and at no cost to members, you may examine documents relevant to your claims/appeals and submit opinions and comments.

Covered member who become eligible for ***Medicare primary*** coverage should enroll in ***Medicare*** Parts A and B. Once a covered member becomes eligible for ***Medicare primary*** coverage, Sandia will pay benefits only as secondary payer, regardless of whether the member enrolled in ***Medicare*** Parts A and B. Claims will be paid as though the covered member enrolled in ***Medicare*** Parts A and B.

Note: For ***COB*** with ***Medicare***, refer to Section 10, Medicare and How Coverage is Coordinated with the CIGNA Senior Premier PPO Plan.

Obtaining Reimbursement

IMPORTANT

*All claims must be submitted within 12 months after the date of service be eligible for consideration of payment. The 12-month requirement will not apply if you are legally incapacitated. If your claim relates to an **inpatient** stay, the date of service is the date your **inpatient** stay ends.*

Filing medical care claims for reimbursement is generally required only under the out-of-network option. Most providers in the CIGNA network will file claims for you. Check with your providers to verify that they will submit your claims.

To obtain reimbursement for medical care coverage under this Plan, attach the itemized medical bill to the claim form and mail it to the address shown on the claim form or the address on the back of your CIGNA HealthCare ***ID*** card. Itemized medical bills should include:

- Patient's full name
- Data and place of treatment or purchase
- Diagnosis
- Type of service provided
- Amount charged
- Name and address of provider and tax identification number
- If other insurance is primary, the ***EOB*** (from the primary insurer) is attached to your claim form

How to Submit Claim Form

You may obtain a claim form from Sandia ***HBES*** (Building 832 East or (505) 844-4237) or from CIGNA HealthCare by calling 1-800-244-6224 or online at www.cigna.com.

The claim form should be completed only if the provider is not submitting the claim on your behalf.

If you are completing the form by hand, use a new printed form rather than a photocopy, print clearly, and use black ink when you complete the form. This ensures that the claim form can be scanned into the system. Do not staple your bills to your claim form.

Benefits Payment

CIGNA HealthCare sends payment to the provider, unless the provider is not contracted with CIGNA HealthCare and you submit a receipt that shows you paid in full (a zero balance) with your itemized bill and the claim form. CIGNA HealthCare reserves the right to request additional documentation, such as medical records, before processing your claim.

Note: The person who received the service is ultimately responsible for payment of services received from providers.

If any benefits of the Plan shall be payable to the estate of a covered member, or to a minor, or individual who is incompetent to give a valid release, the Plan may pay such benefits to any relative or other person whom the Plan determines to have accepted competent responsibility for such minor or individual who is incompetent to give a valid re-

lease or as otherwise required by law. Any payment made by the plan in good faith pursuant to this provision shall fully discharge this Plan and the company to the extent of such payment.

Members cannot assign, pledge, borrow against, or otherwise promise any benefit payable under this Plan before receipt of that benefit. Interest in this Plan is not subject to the claims of creditors. Exceptions include:

- A ***QMCSO*** that requires a health plan to provide benefits to the primary covered member's child.
- Subject to the written direction of a primary covered member, all or a portion of benefits provided by this Plan may, at the option of this Plan and unless the individual requests otherwise in writing, be paid directly to the person rendering such service. Any payment made by this Plan in good faith pursuant to this provision shall fully discharge this Plan and the company to the extent of such payment.

CIGNA HealthCare will send the covered member an ***EOB*** statement after processing the claim. If any claims are denied in whole or in part, the ***EOB*** will include the reason for the denial or partial payment. The ***EOB*** is not a bill. Your provider of service will send you a bill for any balance due. Ask your provider for a detailed explanation if you are billed for more than the patient responsibility amount as indicated on your ***EOB***. You can also view and print your ***EOBs*** online at www.mycigna.com.

IMPORTANT

*All claims must be submitted within 12 months after the date of service to be eligible for consideration of payment. The 12-month requirement will not apply if you are legally incapacitated. If your claim relates to an **inpatient** stay, the date of service is the date your **inpatient** stay ends.*

Timing of Claims Payments

Separate schedules apply to the timing of claims, depending on the type of claim. There are four types of claims:

- ***Urgent care***—a claim for benefits provided in connection with ***urgent care services***.
- Pre-service—a claim for benefits that the Plan must approve before non-urgent care is provided.
- Concurrent care—a claim for benefits whereby the Plan had been reimbursing for the care and a determination was made that the care was no longer eligible for reimbursement.
- Post-service—a claim for reimbursement of the cost of non-urgent care that has already been provided.

Urgent Care Claims

Time Frame for Response from CIGNA HealthCare

Urgent claims will be decided as soon as possible. Notice of the decision (whether adverse or not) must be provided, considering medical exigencies, no later than 72 hours after receipt of the claim.

Extension

If additional information is needed to make a claim decision, CIGNA HealthCare may extend the time frame for providing a response by up to 48 hours from the time the information is received or the initial period expires.

Period for Claimant to Complete Claim

If an extension in processing is required because the claimant has failed to submit sufficient information to allow determination of the claim, the claimant has at least 48 hours after receipt of notice to provide missing information.

Other Related Notices

Notice that a claim is improperly filed or is missing information must be provided as soon as possible but no later than 24 hours from receipt of claim.

Non-urgent Pre-service Claims

Time Frame for Response from CIGNA HealthCare

Pre-service determination of benefit (whether adverse or not) must be provided within a reasonable period of time, appropriate to medical circumstance, but no later than 15 days.

Extension

CIGNA HealthCare may extend the original time frame by up to 15 days if necessary due to matters beyond the Plan's control. CIGNA HealthCare must notify the claimant of the extension before the initial period ends.

Period for Claimant to Complete Claim

If an extension in processing is required because the claimant has failed to submit sufficient information to allow determination of the claim, the claimant will be notified and given at least 45 days from the notice to provide missing information.

Non-urgent Post-service Claims

Time Frame for Response from CIGNA HealthCare

Post-service claim decisions notices (whether adverse or not) must be provided within a reasonable period of time but no later than 30 days.

Extension

CIGNA HealthCare may extend the original time frame by up to 15 days if necessary due to matters beyond the Plan's control. CIGNA HealthCare must notify the claimant of the extension before the initial period ends.

Period for Claimant to Complete Claim

If an extension in processing is required because the claimant has failed to submit sufficient information to allow determination of the claim, the claimant will be notified and given at least 45 days from receipt of the notice to provide missing information. CIGNA HealthCare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Concurrent Care Claims

Time Frame for Response from CIGNA HealthCare

Concurrent care adverse claim decisions must be provided sufficiently in advance to give claimants an opportunity to appeal and obtain a decision before the benefit is reduced or terminated. A request to extend a course of treatment will receive a response within 24 hours, if the claim is made at least 24 hours before the expiration of the period of time or number of treatments. The Plan provides that the benefit reimbursement be maintained for up to 60 calendar days from the date of the first letter of denial for sufficient time for the participant to appeal.

Contents of Notice and Response from CIGNA HealthCare

The notice will include all of the following:

- Specific reason(s) for the denial
- Specific references to the Plan provisions(s) upon which the denial is based
- Description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary
- Explanation of the Plan's appeal procedure, its deadlines, including, if applicable, the expedited review available for urgent claims, and the claimant's right to bring civil action under Section 502(a) of ***ERISA*** following an adverse decision on your appeal

- Copy of any rule or guideline relied upon in making the adverse determination, or a statement that the rule or guideline was relied upon and will be provided, upon requests, free of charge
- Explanation of the specific or clinical judgment for the adverse determination whether based on medical necessity or ***experimental*** treatment or similar exclusion or limit by applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Claims Denials and Appeal

Sandia is committed to capturing, as error-free as possible, the information you provide us. CIGNA HealthCare uses this information to review and process your claims as quickly and accurately as possible.

If CIGNA HealthCare denies your (or your dependent's) claim because of eligibility, refer to Section 2, Eligibility for eligibility appeals procedures.

If you dispute a denial by the CIGNA HealthCare of your claim based on Plan coverage or you want to challenge a benefit determination, you have the right to request that CIGNA HealthCare reconsider its decision. The procedure for appealing to CIGNA HealthCare is outlined below.

If you have a claim denied because of…	then…
eligibility to enroll in the Plan (except for disability determinations)	contact Sandia HBES at (505) 844-4237.
benefits administration or any other reason	contact CIGNA HealthCare at 1-800-244-6224.

Filing an Appeal

If a claim for benefits is denied in part or in whole, you have the right to appeal the claim. CIGNA HealthCare will conduct a full and fair review of your appeal.

Regardless of the decision and/or recommendation of CIGNA HealthCare or what the plan will pay, it is always up to the member and the doctor to decide what, if any, care he or she receives.

CIGNA HealthCare has established procedures for hearing, researching, recording, and resolving any appeals or complaints a covered member may have. The appeal procedure is limited to covered members and to formerly covered members seeking to resolve a dispute that arose during coverage.

For urgent claims that have been denied, you or your provider may call CIGNA HealthCare at 1-800-244-6224 to request an appeal.

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

- Patient's name and ***ID*** number as shown on the ***ID*** card
- Provider's name
- Date of medical service
- Reason you think your claim should be paid
- Documentation or other written information to support your request.

Send the written appeal to:

CIGNA HealthCare
Appeals Department
700 N. Brand Blvd
Glendale, CA 91203.

Two Levels of Appeals

Two levels of appeals are permitted for each type of claim that is denied. These are described in the following steps:

Step 1: First Level of Appeal

- CIGNA HealthCare will attempt to resolve the complaint informally through review of previous medical information received, ***physician*** office records, and additional medical information requested from the ***physicians***.
- Treatment may be reviewed by another ***physician*** with the same specialty, and who was not consulted during the initial benefit determination.

Step 2: Second Level of Appeal

- If you are not satisfied with the first-level appeal decision, you have the right to request a second-level appeal within 60 days from receipt of the first-level appeal.

Timing of Appeals Decisions

Separate schedules apply to the timing of claims appeals, depending on the type of claim: ***urgent care***, pre-service, or post-service claims. If the claimant does not receive a written response from the CIGNA HealthCare within the time periods described above, the claimant should treat the claim as denied and proceed immediately to the next level of appeal, request an external review, or seek legal recourse.

IMPORTANT

You must exhaust the appeal process before you request an external review or seek other legal recourse.

Urgent Care Claims

Period for Filing Appeals

The claimant has at least 180 days for filing the first level of appeal.

> **Note:** You do not need to submit an ***urgent care*** claim appeals in writing. You should call CIGNA HealthCare as soon as possible to appeal an ***urgent care*** claim.

Time Frame for Response from CIGNA HealthCare

Response must be provided as soon as possible taking into account medical exigencies, but no later than 72 hours. There is a maximum of two levels of mandatory review.

Non-urgent Pre-service Claims

Period for Filing Appeals

The claimant has at least 180 days for filing the first level of appeal.

Time Frame for Response from CIGNA HealthCare

Response must be provided within a reasonable period of time, appropriate to medical circumstance, but no later than 30 days. Response must be provided within 15 days of each appeal.

Non-urgent Post-service Claims

Period for Filing Appeals

The claimant has at least 180 days for filing the first level of appeal.

Time Frame for Response from CIGNA HealthCare

Response must be provided within a reasonable period of time, but no later than 60 days. A notice of adverse claim appeal must be provided within a reasonable period of time, but no later than 30 days after each appeal.

External Review

If you are not satisfied with the decision following completion of the second-level appeal process, and your claim was denied based upon lack of medical necessity or the ***experimental*** nature of the treatment, and if your claim was above $1,000, you may request that your claim be reviewed by an external independent review organization.

The independent review organization is composed of persons who are not employed by CIGNA HealthCare or any of its affiliates. There is no charge for you to initiate this independent review process. CIGNA HealthCare will abide by the decision of the independent review. Administrative eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must write to CIGNA HealthCare at the address above within 180 days of your receipt of the second-level appeal denial. You may provide additional information to be considered. CIGNA HealthCare will acknowledge receipt of your request and will notify you when your file has been sent for external review.

The independent reviewer will render an opinion within 60 days upon receipt of all information. If you are not satisfied with the outcome of this review, you have the right to seek legal recourse.

IMPORTANT

CIGNA HealthCare, has the exclusive right to interpret the provisions of this Plan (with the exception of eligibility provisions), to construe its terms, to determine the amount and level of benefits payable and to determine disability status as required for continuation as Class I dependent after age 24. The determination of the CIGNA HealthCare is conclusive and binding.

Recovery of Excess Payment

CIGNA HealthCare, the claims administrator, has the right at any time to recover any amount paid by this Plan for charges in excess of the covered benefits under this Plan provisions. Payments may be recovered from covered members, providers of service, and other medical care plans.

IMPORTANT

By accepting benefits under this Plan, the covered member agrees to reimburse payments made in error and cooperate in the recovery of excess payments.

Section 12. When Coverage Stops

This section outlines when coverage stops for the primary covered member and their eligible Class I and Class II dependents as well as causes for termination by CIGNA HealthCare.

Primary Covered Member

Plan benefits for primary covered members stop on the:

- Date the Plan is terminated
- Last day of the month in which any cost of the coverage is not paid when due
- Date of death
- Last day of the month before the month in which the member becomes eligible for ***Medicare primary*** coverage
- Submission of a fraudulent claim

IMPORTANT

Health care coverage may be continued in some situations (refer to Section 13, Continuation of Group Health Coverage, for ***COBRA*** *rules).*

Class I and Class II Dependents

Plan benefits for dependents stop on the:

- Last day of the month in which the dependent becomes eligible for coverage as an employee under any Sandia-sponsored medical plan
- Last day of the month that any cost of coverage for dependents is not paid when due
- Last day of the month in which a Class II dependent becomes ineligible for coverage
- Date primary covered member's coverage stops
- Last day of the month in which the dependent spouse legally divorces or effects a legal separation or an annulment from the primary covered member
- Last day of the month in which a dependent child marries or ceases to be eligible under the definition of dependent
- Last day of the month in which the primary covered member terminates (disenrolls) dependent coverage

Note: You must disenroll your dependents within 31 calendar days of the date your dependent becomes ineligible for coverage under this Plan.

Refer to Section 13, Continuation of Group Health Coverage, to determine whether your dependent may be eligible for temporary continued coverage under ***COBRA*** and refer to the ***Pre-Tax Premium Plan*** booklet for specific rules regarding dropping dependent coverage if your medical contribution is taken on a pre-tax basis.

Termination for Cause

CIGNA HealthCare may terminate a member's coverage for cause, upon 30 days written notice, or with written notice effective immediately for gross misconduct. Cause for termination of a member may include any of the following:

- Failure to pay ***copayments***
- Permitting an unauthorized person to use your identification card (unless you notified CIGNA HealthCare to report that your card was lost or stolen)
- Repeated failure to make or keep appointments for medical care
- Declination of Plan benefits
- Abuse of Plan coverage by providing false information on applications or forms
- Failure to follow Plan rules and regulations
- Verbal or physical threats to a CIGNA HealthCare's employee, ***physician***, or network provider
- Fraudulent receipt of Plan services for noncovered persons
- Failure to comply with ***subrogation*** rules

Covered members terminated for cause are not eligible for any of this Plan's continuation of group health coverage

Certificate of Group Health Plan Coverage

Sandia complies with the requirements of the Health Insurance Portability and Accountability Act (***HIPAA***), Pub. L. 104-191, enacted on August 21, 1996. ***HIPAA*** amended the Public Health Service Act (PHS Act), the Employee Retirement Income Security Act of 1974 (***ERISA***), and the Internal Revenue Code of 1986 (Code). The amendment provides for, among other things, improved portability and continuity of health insurance coverage in the group and individual insurance markets and group health plan coverage provided in connection with employment.

When the Sandia ***HBES*** learns of your loss of medical coverage, or the loss of coverage for your dependents, you will be sent a Certificate of Group Health Plan Coverage. This

certificate provides proof of your prior health care coverage for the past 18 months or less of coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the six-month period before your enrollment in the new plan. If you become covered under another group health plan, check with your new plan administrator to see if you need to provide this certificate. You may also need this certificate to buy an insurance policy for yourself or your family member that does not exclude coverage for medical conditions that are present before you enroll.

You have the right to request (for up to two years following the event that caused the loss of coverage) a Certificate of Group Health Plan Coverage by contacting Sandia's ***HBES***.

Section 13. Continuation of Group Health Coverage

This section outlines the opportunities given covered members under a Sandia-sponsored medical plan to continue the employer-provided health coverage.

Continued employer-provided health coverage is subject to the stated qualifications and requirements of participation in each Sandia health plan. Sandia offers the following covered members the opportunity to continue Sandia-sponsored medical coverage:

- Employees who retire
- Employees who are approved for and receiving Long-Term Disability through Sandia
- Surviving spouse and dependents
- ***COBRA*** eligible persons

Retiree Medical Plan Option

If you retire from Sandia with a service pension or a disability pension, you are eligible for continued medical coverage through Sandia under the Retiree Medical Plan Option. You will be allowed to change your medical plan choice every year during the Open Enrollment period Sandia holds in the fall.

Medicare primary retirees under the Retiree Medical Plan Option are eligible to enroll in the CIGNA Senior Premier ***PPO*** or to enroll in the Lovelace Senior Plan (certain counties in NM). Unless you elect to enroll in your plan of choice within 31 calendar days of your retirement date, the CIGNA Senior Premier ***PPO*** will be your Sandia-sponsored medical care plan. The ***Medicare primary*** covered retiree and/or covered dependents will be defaulted into the CIGNA Senior Premier ***PPO*** if an election is not made.

All ***Medicare primary*** family members must be enrolled in the same plan and all non-***Medicare primary*** family members must be enrolled in the same plan.

> **Note:** If you are a ***dual Sandian*** and your spouse remains an employee, you have the option of enrolling as a dependent under your spouse, or if your spouse is already a retiree, you can change your election as to who is covered under whom.

As an alternative to electing coverage under the Retiree Medical Plan Option, the retiree may elect to temporarily continue the same medical coverage as available to active employees by making an election under ***COBRA***. If the retiree elects ***COBRA*** coverage instead of coverage under the Retiree Medical Plan Option, the retiree cannot elect the Re-

tiree Medical Plan Option after their ***COBRA*** coverage has terminated. If the retiree elects the Retiree Medical Plan Option, he or she must waive his or her rights to ***COBRA***.

Long-Term Disability (LTD) Terminee Medical Plan Option

If you terminate employment because of a disability and you are approved for and receiving long-term disability benefits through Sandia, you are eligible to continue medical coverage through Sandia until the end of the month in which you recover and the Plan benefit ceases, the Plan benefit ceases for any other reason, or you die. You will be allowed to change your medical plan choice every year during the Open Enrollment period Sandia holds in the fall.

If you are under age 65 and have been receiving Social Security disability benefits for 24 months or longer or if you are age 65 or older, you are eligible for ***Medicare primary*** coverage. ***Medicare*** will become your primary coverage.

As a ***LTD terminee***, you are eligible to enroll in the CIGNA Senior Premier PPO Plan or the Lovelace Senior Plan (certain counties in NM) if you enroll within 31 calendar days of becoming eligible for ***Medicare primary*** coverage. The ***Medicare primary*** disability terminee and/or eligible covered dependents will be defaulted into the CIGNA Senior Premier PPO if an election is not made.

All ***Medicare primary*** family members must be enrolled in the same plan and all non-***Medicare primary*** family members must be enrolled in the same plan.

As an alternative to electing coverage under the ***LTD Terminee*** Medical Plan Option, the ***LTD terminee*** may elect to temporarily continue the same medical coverage as available to active employees by making an election under ***COBRA***. If the ***LTD terminee*** elects ***COBRA*** coverage instead of coverage under the***LTD Terminee*** Medical Plan Option, the ***LTD terminee*** cannot elect the ***LTD Terminee*** Medical Plan Option after their ***COBRA*** coverage has terminated. If the ***LTD terminee*** elects the ***LTD Terminee*** Medical Plan Option, he or she must waive his or her rights to ***COBRA***.

Surviving Spouse Medical Plan Option

If you are a survivor or dependent of an on-roll regular employee or a Sandia retiree who dies while covered under this Plan, you are eligible to continue medical coverage through Sandia under the Surviving Spouse Medical Plan Option. You will be allowed to change your medical plan choice every year during the Open Enrollment period Sandia holds in the fall.

Sandia pays a portion of the full premium for continued employer-provided, health coverage for the first six months.

Exception

Sandia does NOT pay for the first six months of coverage for survivors of those retired employees paying their own premiums at the time of death.

The surviving spouse and dependents may continue medical coverage for life under the Surviving Spouse Medical Plan Option if the election to continue coverage is made within the first six months of death and by paying the applicable premium for medical coverage.

The surviving dependent ***children*** with no surviving parent may continue medical coverage up to an additional 30 months of coverage (beyond the initial first six months at the applicable employee or retiree premium-share amount) by paying the applicable premium for coverage under ***COBRA***.

As an alternative to electing coverage under the Surviving Spouse Medical Plan Option, the surviving spouse and any surviving dependents may elect to temporarily continue the same medical coverage as available to active employees or non-***Medicare primary*** retirees (whichever is applicable) by making an election under ***COBRA***. If the surviving spouse elects ***COBRA*** coverage instead of coverage under the Surviving Spouse Medical Plan Option, the surviving spouse cannot elect the Surviving Spouse Medical Plan Option after their ***COBRA*** coverage has terminated. If the surviving spouse elects the Surviving Spouse Medical Plan Option, he or she must waive his or her rights to ***COBRA***.

Special Rules

- All Class I and Class II dependents covered at the time of death of the employee or retiree are eligible for continued medical coverage through Sandia.
- No new dependents can be added except for ***children*** born or adopted with respect to a pregnancy or placement for adoption that occurred before the employee's or retiree's death.
- A survivor cannot add a Class II dependent even if that dependent is a Class I dependent at the time of the employee's or retiree's death.

Termination Rules

For the surviving spouse and dependents, coverage terminates if:

- The spouse marries
- A surviving spouse dies

Note: If a surviving spouse dies, any covered dependents under the spouse may have ***COBRA*** rights.

- Payments are not received when due

Refer to Section 4, Group Health Plan Premiums, for premium costs for continuation of group health care coverage.

COBRA

The federal law known as the Consolidated Omnibus Budget Reconciliation Act (***COBRA***) requires Sandia to offer temporary continuation of the same group health coverage as previously in effect to the covered employee, retiree, or other former employee, and the covered spouse, and the covered dependent ***child(ren)*** of the employee, retiree, or other former employee when a ***qualifying event*** causes the individual to lose his/her group health coverage.

COBRA-qualified beneficiaries may temporarily continue coverage through Sandia by notifying Sandia of a ***qualifying event*** (other than termination, reduction of hours, or death of an employee). ***COBRA*** coverage will continue for ***qualified beneficiaries*** who pay the applicable premium for continued medical coverage under ***COBRA***, plus a two percent administrative fee, in a timely manner.

Note: A dependent child who is born to or placed for adoption with the employee or retiree during a period of ***COBRA*** continuation coverage is a qualifying beneficiary.

Covered members who become eligible for ***Medicare primary*** coverage should enroll in ***Medicare*** Parts A and B. Once a covered member becomes eligible for ***Medicare primary*** coverage, Sandia will pay benefits **only** as secondary payer of benefits, regardless of whether or not the member enrolled in ***Medicare*** Parts A and B. Claims will be paid as though the covered member is enrolled in both ***Medicare*** Parts A and B.

IMPORTANT

*If a covered member**covered member**, who is eligible for **Medicare primary** coverage, is provided primary coverage under this or any other Sandia-sponsored medical plan, the primary covered member will be responsible for reimbursing Sandia for any ineligible benefits.*

Qualifying Events Causing Loss of Coverage

The following table describes how an individual may become a ***qualified beneficiary*** due to the events causing loss of coverage and thus making those individuals eligible for continued coverage through Sandia and the maximum period of continuation coverage that is available under ***COBRA***.

You are the Qualified Beneficiary if you are the…	and if you, a covered member, loses coverage under this Plan due to…	Maximum Period of Continuation Coverage…
Employee Spouse Dependent Child	• Termination of employee's employment for any reason other than gross misconduct or reduction in employee's hours of employment	18 months*
Employee Spouse Dependent Child	• Termination of employment (for any reason other than gross misconduct or reduction in employee's hours of employment), and you are disabled or become disabled within the first 60 days of your COBRA coverage, as determined by Social Security, and you do not have Medicare coverage[1]	29 months from the original COBRA qualifying event (after the first 18 months you will be charged 150% of the cost of the applicable group rate).
Spouse Dependent Child	• Covered employee, retiree, or long-term disability terminee becomes entitled to Medicare • Divorce or legal separation of the spouse from the covered employee, retiree, or long-term disability terminee • Death of the covered employee, retiree, or long-term disability terminee	36 months
Dependent Child	• Loss of dependent child status under the plan rules	36 months

*You may become entitled to an 18-month extension of your COBRA coverage (for a total maximum period of 36 months of continuation coverage) if you experience a second qualifying event such as the death of the primary qualified beneficiary, the divorce or legal separation from the primary qualified beneficiary, the primary qualified beneficiary becoming entitled to Medicare, or a loss of dependent child status under the plan.

The second event can be a second qualifying event only if it would have caused you to lose coverage under the Plan in the absence of the first qualifying event. If a second qualifying event occurs, notify the Sandia HBES.

[1] You must notify Sandia HBES at (505) 844-4237 within 60 days of the date Social Security determines that you or a family member is disabled and within the first 18 months of COBRA continuation of coverage. If you fail to notify Sandia, you will lose your right to the additional COBRA coverage. If you fail to inform Sandia HBES within 60 days of the notification date, you will no longer be eligible to participate in COBRA.

Notification of Election of COBRA

The following table shows notification and election actions for temporary continued coverage under ***COBRA***.

Step	Who	Action
1	Primary Covered Member or family member	Notify Sandia HBES, in writing, within 60 days[1] after the date on which the following qualifying event: • Divorce • Legal separation • Annulment • Loss of a child's dependent status • Disability designation by Social Security • Death of a primary covered member other than an employee. **Send notice to:** Sandia National Laboratories Attention: Benefits Department, Mail Stop 1022 P. O. Box 5800 Albuquerque, NM 87185
2	Sandia HBES	Notify Sandia Benefits COBRA administrator of covered member's qualifying event (including termination or reduction of hours of employment, death of employee, etc.).
3	Sandia Benefits COBRA administrator	Notify qualified beneficiaries of their right to continue medical coverage through Sandia and how to make an election. The notice must be provided to the qualified beneficiaries within 14 days after the COBRA administrator receives the notice of a qualifying event. You may contact the COBRA administrator by calling Sandia HBES at (505) 844-4237.
4	Qualified beneficiary	Contact the Sandia Benefits COBRA administrator to elect COBRA coverage. • Qualified beneficiary has 60 days to elect COBRA starting on the later of the date he/she is furnished the COBRA rights notice or the date he/she would lose coverage. • Qualified beneficiary must make initial premium payment within 45 days from the COBRA election date. The plan allows the beneficiary a 30-day grace period for monthly premium payment thereafter.

[1] You must notify Sandia HBES at (505) 844-4237 within 60 days of the date Social Security determines that you or a family member is disabled and within the first 18 months of COBRA continuation of coverage. If you fail to notify Sandia, you will lose your right to the additional COBRA coverage. If you fail to inform Sandia Benefits within 60 days of the notification date, you will no longer be eligible to participate in COBRA.

Step	Who	Action
		• **If beneficiary elects to continue coverage**, Sandia provides coverage under the Plan at his/her expense plus the administrative fee. • **If beneficiary does not elect to continue coverage** during the 60-day election period, then medical coverage through Sandia ends at the end of the month in which the event occurred and the qualified beneficiary became ineligible for coverage. • Failure to make any payment within the payment date requirement described above will cause you to lose all COBRA rights. • Following the initial payment, if beneficiary does not pay a premium by the first day of a period of coverage, the plan has the option to cancel his/her coverage until payment is received and then reinstate the coverage retroactively back to the beginning of the period of coverage. Retroactive reinstatement is not available unless payment is received within 30 calendar days of the due date. • If the amount of payment is wrong, but is not significantly less than the amount due, the Plan is required to notify the beneficiary of the deficiency and grant a period of no longer than 30 days to pay the difference. The Plan is not obligated to send monthly premium notices.
5	Sandia Benefits COBRA administrator	Notify qualified beneficiaries of early termination of COBRA continuation coverage if it will end before the maximum period that COBRA coverage is available.

Benefits Under Temporary Continuation Coverage

As a ***qualified beneficiary*** you have the following rights under ***COBRA***:

- Identical coverage that is currently available under the Plan to similarly situated employees, retirees, and their families
- Benefits choices and services that a similarly situated participant or beneficiary is currently receiving under the Plan, such as the right to choose among available coverage options during the annual Open Enrollment period held by Sandia each fall
- Rules and limits that would apply to a similarly situated participant or beneficiary, such as ***copayment*** requirements, ***deductibles***, and coverage limits. The Plan's rules for filing benefit claims and appealing any claims denials also apply.

Any changes made to the Plan's terms that apply to similarly situated active employees, retirees, and their families will also apply to ***qualified beneficiaries*** receiving ***COBRA*** continuation coverage.

Termination of Temporary Continuation Coverage

Early termination of continuation coverage may occur for any of the following reasons:

- Premiums are not paid in full on a timely basis
- Sandia ceases to maintain any group health plan
- A ***qualified beneficiary*** begins coverage under another group health plan after electing continuation coverage under Sandia, and that plan does not impose an exclusion or limitation affecting a pre-existing condition of the ***qualified beneficiary***
- A ***qualified beneficiary*** becomes entitled to ***Medicare*** benefits after electing continuation coverage
- A ***qualified beneficiary*** engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud)

Coverage extensions required under other laws (e.g., state law) or provided by other provisions of the Plan, such as ***leaves of absence*** (excludes FMLA), continue concurrently with (i.e., count toward) temporary continued coverage, mandated by ***COBRA***.

Disability Extension and Multiple Qualifying Events

COBRA coverage may be extended (as previously discussed) under the following circumstances:

- If an individual is disabled (as determined by Social Security) before or during the first 60 days of an 18-month ***COBRA*** period, all of the individual's ***COBRA***-eligible family is eligible for an 11-month extension of coverage up to a maximum of 29 months from the original ***COBRA qualifying event***. After the first 18 months of ***COBRA*** coverage, you will be charged at 150% of the cost of the applicable group rate.
    - The individual must provide a copy of the Social Security determination within 60 days of the date the disability determination was made and no later than 18 months after the election change event. He/she must also provide notice within 30 days of determination that the ***qualified beneficiary*** is no longer disabled.

- In the event of a second election change event (e.g., divorce, ***qualified beneficiary*** dies or becomes covered by ***Medicare***, dependent child loses dependent status) that occurs during the 18-month ***COBRA*** coverage period (or during disability extension), the spouse and ***children*** already receiving continuation coverage may be eligible for additional months of coverage, up to a maximum of 36 months from the date of the original election change event. The employee must notify Sandia ***HBES*** of the second election change event within 60 days.

Section 14. CIGNA HealthCare Services

This section outlines the customer services provided by the claims administrator, CIGNA HealthCare, to covered members.

Member Services

Member services are provided through the CIGNA HealthCare Member Service Unit at 1-800-244-6224, Monday through Friday, from 8:00 a.m. to 6:00 p.m. (MST). Member services include:

- Benefits information
- Claims status
- Case management
- Disease management
- ***ID*** cards
- ***Pre-certification***
- ***Prior authorization***
- Provider searches
- ***Utilization review***

If you are not satisfied with the Member Service Unit, a CIGNA HealthCare representative is available to assist covered members with day-to-day questions and issues including explanation of Plan provisions, access to care issues, billing issues and appeals. Call Sandia ***HBES*** (505) 844-4237 to get in touch with a CIGNA HealthCare representative.

CIGNA HealthCare Open Access Plus ID Card

CIGNA HealthCare provides each covered member an ***ID*** card that shows your Plan participation and certain coverage levels such as ***deductible*** and ***coinsurance*** percentage on the front. The back of your ***ID*** card shows CIGNA's toll-free number for member services and the address to file claims. To facilitate efficiency of service provided and ensure that your claims are handled properly:

- Carry your CIGNA HealthCare ***ID*** card with you at all times and show it whenever you access medical care.
- Show your CIGNA HealthCare member ***ID*** card whenever you access medical care or services from a:
    - ***Physician*** or ***specialist***
    - ***Hospital***

- Lab, X-ray, mammography, MRI, or other facility
- ***Emergency*** room
- Pharmacy

Hospital Admissions

Call CIGNA HealthCare at 1-800-244-6224 whenever you are hospitalized. It is your responsibility to make sure that you have received the necessary authorization, called ***pre-certification,*** for your ***hospital*** stay. Call CIGNA HealthCare a minimum of five days before a scheduled admission. If you are unable to call five days in advance, you should call as soon as you know you will need ***hospital*** care. The toll-free number is on your CIGNA HealthCare ***ID*** card.

If the service is for mental health or ***substance abuse***, ask to speak with a CBH customer service representative.

Case Management

CIGNA HealthCare offers case management services to covered members for needs beyond a traditional ***hospital*** stay. An experienced case manager offers valuable counseling, support, and care coordination. The case manager works with you and your doctor to help sort out your options, contact facilities, arrange care, and access helpful community resources and programs. The case manager can help you find ***cost effective***, quality, appropriate care for home care, ***outpatient*** treatment, or rehabilitation. Call the CIGNA toll-free number on the back of your ***ID*** card to learn more about case management.

Emergencies

Call 911 immediately or have someone call for you.

Emergencies are covered under this Plan 24 hours a day, seven days a week, no matter where you are. Whenever a covered member has a serious accident or sudden ***illness*** or injury, and symptoms are severe and occur unexpectedly, seek medical help immediately.

Examples of an ***emergency*** situation include:

- Uncontrolled bleeding
- Seizure or loss of consciousness
- Shortness of breath
- Chest pain or squeezing sensation in the chest
- Suspected overdose of medication or poisoning

- Sudden paralysis or slurred speech
- Severe burns
- Broken bones
- Severe pain

Call CIGNA HealthCare (1-800-244-6224) or have someone call for you within 48 hours or as soon as possible.

If you have any questions about your situation and whether it is an ***emergency***, call your personal doctor.

Urgent Care

Call your personal doctor for prompt medical attention for severe sore throat, ear or eye infection, sprains or strains, and fever. He/she may recommend steps you can take to be more comfortable and may prescribe medication if necessary. If you need to be examined, your doctor will direct you to the most appropriate type of care—***emergency*** room, ***urgent care*** center, or office visit.

Routine Care

Routine physicals, immunizations, colds, or flu, follow-ups for ***injuries*** or broken bones, and prescription needs are all situations that should be handled through regular, scheduled office visits with your doctor.

CIGNA HealthCare 24-Hour Health Information Line (1-800-564-9286)

Health Information Library—available by phone anywhere in the U.S. (anytime of day, seven-days a week). Call 1-800-564-9286 to learn more about hundreds of topics such as bumps, bug bites, back pain, elder care, and cardiology. Simple menus guide you to the information you need.

- Programs are updated regularly and are based on current medical research and treatments.
- You can listen to as many programs as you like.
- If you'd like more information or have a question, the system will automatically connect you with a registered nurse.

Health Information Nurse—available any hour of the day or night for:

- Detailed answers to your specific health questions
- Home care suggestions
- Choosing the most appropriate care—***emergency*** room, ***urgent care***, or a doctor's office visit
- Locating nearby ***participating providers*** when you're away from home

Prescription Drug Coverage

This Plan provides prescription drug coverage. Take your prescription from your doctor along with your CIGNA HealthCare ***ID*** card to a participating pharmacy. All you'll pay is the applicable ***coinsurance*** amount for covered prescriptions. Your CIGNA HealthCare ***ID*** card is accepted at more than 51,000 pharmacies nationwide, including local drug stores and national chains. Check your CIGNA HealthCare Provider Directory or visit the CIGNA HealthCare website at www.cigna.com to find a network pharmacy.

CIGNA HealthCare Website (www.mycigna.com)

You can access your personalized information by registering at www.mycigna.com and get the most recent updated directory of providers including ***physicians***, ***specialists***, behavioral health, and facilities.

If your provider is not contracted with CIGNA HealthCare, he/she can access information about becoming contracted through www.cigna.com or by calling 1-888-882-4462.

Register at www.cigna.com to get your personalized website (www.mycigna.com) information such as:

- **Plan Benefits**—view claim status, order ***ID*** cards or print a temporary one, locate contracted providers, learn about plan benefits and features, and get answers to frequently asked questions
- **Health Quotient**—complete a brief, online Health Risk Assessment. Your Health Risk Assessment results are easy to print and share with your provider
- **Health Tracker**—record your personal medical data
- **Quality Care Tool**—find out how ***hospitals*** rank by number of procedures performed, patients' average length of stay, and cost.

Appendix A. Acronyms and Definitions

Acronyms

COB	coordination of benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPR	Corporate Process Requirement
DME	durable medical equipment
EAP	Employee Assistance Program
EBC	Employee Benefits Committee
EOB	Explanation of Benefits
ERISA	Employee Retirement Income Security Act
FMLA	Family and Medical Leave Act
HBES	Health, Benefits, and Employee Services
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
ID	identification
HDL	high density lipoprotein
HIV	human immunodeficiency virus
ICD-9	International Classification of Diseases—9th edition
IRC	Internal Revenue Code
IRS	Internal Revenue Service
LDL	low-density lipoprotein
LTD Plan	Long-Term Disability Plan
OB/GYN	obstetrical/gynecological
PCP	primary care physician

PPO	Preferred Provider Organization
PTPP	Pre-Tax Premium Plan
QB	qualified beneficiary
QMCSO	Qualified Medical Child Support Order
QNMSN	Qualified National Medical Support Notice
SPD	Summary Plan Description
TMJ	tempormandibular joint
U&C	usual and customary
UM	utilization management

Definitions

alternate payee/alternate recipient

A child or custodial parent who is not a primary covered member and who, because of a Qualified National Medical Support Notice, is entitled to receive reimbursement directly from CIGNA HealthCare.

Behavioral health

Mental health and/or substance abuse

brand-name drug

A drug manufactured by a pharmaceutical company that has chosen to patent the drug's formula and register its brand name.

child(ren)

Child(ren) include:

- The primary covered member's own children and legally adopted children
- Adopted child (if the placement agreement and/or final adoption papers have been completed and submitted to Sandia Benefits)
- Stepchildren living with the primary covered member (stepchildren visiting for the summer are not considered to be living with you)
- Child for whom you have legal guardianship
- Natural child, legally adopted child, or child for whom you have legal guardianship if a court decree requires you to provide coverage.

COBRA

Requires Sandia to offer a temporary extension of health care coverage to primary covered members and dependents who would otherwise lose their group health coverage as a result of certain events.

coinsurance

Cost-sharing feature by which the Plan pays a percentage of the covered charge, and the covered member pays the balance of that covered charge.

congenital anomaly

A physical developmental defect that is present at birth and is identified within the first 12 months of birth.

coordination of benefits (COB)

When a covered member has medical coverage under other group health plans (including Medicare), the Plan benefits are reduced so that the total combined payments from all plans do not exceed 100% of the highest allowed U&C charges or the lowest negotiated fee.

copayment/copay

A flat per-service charge you pay for services such as doctor visits. (HMOs usually have only copays.)

cosmetic procedures

Procedures or services that change or improve appearance without significantly improving physiological function, as determined by CIGNA HealthCare.

cost effective

Least expensive equipment that performs the necessary function. Applies to durable medical equipment and prosthetic appliances/devices.

covered charges

See "covered health services."

covered health services

Covered health services are those health services and supplies that are:

- Provided for the purpose of preventing, diagnosing, or treating illness, injury, mental illness, substance abuse or their symptoms
- Included as a covered benefit in Section 6, Coverages and Limitations
- Provided to a covered member who meets the Plan's eligibility requirements.

covered member

An eligible employee, retiree, surviving spouse, or COBRA covered person who has coverage under the Plan and his or her dependents who have coverage under the Plan.

custodial care

Services or supplies, regardless of where or by whom they are provided, that

- A person without medical skills or background could provide or could be trained to provide
- Are provided mainly to help the covered member with daily living activities, including (but not limited to)

- Walking, getting in and/or out of bed, exercising and moving the covered member
- Bathing, using the toilet, administering enemas, dressing, and assisting with any other physical or oral hygiene needs
- Assistance with eating by utensil, tube, or gastrostomy
- Homemaking, such as preparation of meals or special diets, and house cleaning
- Acting as a companion or sitter
- Supervising the administration of medications that can usually be self-administered, including reminders of when to take such medications

- Provide a protective environment
- Are part of a maintenance treatment plan or are not part of an active treatment plan intended to or reasonably expected to improve a covered member's illness, injury, or functional ability
- Are provided for the convenience of the covered member or the caregiver or are provided because of the covered member's own home arrangement are not appropriate or adequate.

deductibles

The dollar amount you must pay each year before the Plan begins to pay benefits for certain covered expenses. The amount of the deductible depends upon the plan you select.

developmental care

Services or supplies (regardless of where or by whom they are provided) that

- Are provided to a member who has not previously reached the level of development expected for the member's age in the following areas of major life activity:
  - Intellectual
  - Physical

- Receptive and expressive language
- Learning
- Mobility
- Self-direction
- Capacity for independent living
- Economic self-sufficiency

- Are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to injury or illness)
- Are educational in nature.

dual Sandians

Both spouses are employed by or retired from Sandia.

durable medical equipment (DME)

Equipment (e.g., hospital beds, wheelchairs, walkers, C-PAP machine, etc.) determined by the CIGNA HealthCare to meet the following criteria:

- Is prescribed by a licensed physician
- Is medically necessary
- Is not primarily and customarily used for a non-medical purpose
- Is designed for prolonged use
- Serves a specific therapeutic purpose in treatment of an injury or illness.

Employee Assistance Program (EAP)

Short-term counseling or referral for personal or professional development for members experiencing impairment from personal concerns that adversely affects day-to-day activity including:

- Health
- Marriage
- Family
- Finances

- Substance abuse
- Legal issues
- Stress.

EAP counselor A licensed master's- or Ph.D.-level mental health clinician who provides information, assessment, short-term counseling, and referrals.

eligible expenses Charges for covered health services that are provided while the Plan is in effect, determined as follows:

- In-network benefits—contracted rates with the provider
- Out-of-network benefits
    - selected data resources which, in the judgment of the claims administrator, represents competitive fees in that geographic area or
    - negotiated rates agreed to by the out-of-network provider and either the claims administrator or one of its vendors, affiliates or subcontractors

These provisions do not apply if you receive covered health services from an out-of-network provider in an emergency. In that case, eligible expenses are the amounts billed by the provider, unless the CIGNA HealthCare negotiates lower rates.

Eligible expenses are subject to CIGNA HealthCare's reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from CIGNA HealthCare.

emergency See "medical emergency."

experimental/investigative

Any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical practice in the state in which services are provided. In addition, if federal or other governmental agency approval is required for use of any items and such approval was not granted at the time services were administered, the service is experimental. To be considered standard medical practice and not experimental or investigative, treatment must meet all five of the following criteria:

- A technology must have final approval from the appropriate regulatory government bodies
- The scientific evidence as published in peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcomes
- The technology must improve the net health outcome
- The technology must be as beneficial as any established alternatives
- The improvement must be attainable outside the investigational settings.

Explanation of Benefits (EOB)

CIGNA HealthCare will provide a statement (EOB) to explain the benefits provided, the allowable reimbursement amounts, any deductibles, coinsurance, and other adjustments taken, and the net amount paid. A participant typically receives an EOB with a claim reimbursement check or as confirmation that a claim has been paid directly to the provider.

financially dependent person

Persons who receive greater than 50% of their financial support for the calendar year from the primary covered member.

follow-up care

Re-examination of or maintenance of contact with a patient at prescribed intervals following diagnosis or treatment.

generic drug

A prescription drug that has the same active-ingredient formula as a brand-name drug. A generic drug is known only by its formula name and its formula is available to any pharmaceutical company. Generic drugs are rated by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs and are typically less costly.

hospice

A program provided by a licensed facility or agency that provides home health care, homemaker services, emotional support services, and other services provided to a terminally ill person whose life expectancy is six months or less as certified by the person's physician.

hospital

An institution licensed as a hospital that

- Maintains, on the premises, all facilities necessary for medical and surgical treatment
- Provides such treatment on an inpatient basis, for compensation, under the supervision of physicians
- Provides 24-hour service by registered graduate nurses
- An institution that qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals.

An institution that

- Specializes in treatment of mental illness, alcohol or drug abuse, or other related illness
- Provides residential treatment programs
- Is licensed in accordance with the laws of the appropriate legally authorized agency.

Hospital does not include a hospital or institution or part of a hospital or institution that is licensed or used principally as a clinic, convalescent home, rest home, nursing home, home for the aged, halfway house, or board and care facilities.

hospital confinement	A medically necessary hospital stay of 24 consecutive hours or more in any single or multiple departments or parts of a hospital for the purpose of receiving any type of medical service. These requirements apply even if the hospital does not charge for daily room and board. How the hospital classified the stay is irrelevant. Any hospital confinement satisfying this definition will be subject to all contract provisions relating to inpatient hospital services or admissions, including any applicable preadmission review requirements. Hospital stays or services not satisfying this definition will be considered under the contract provisions for outpatient services.
illness	A disease, disorder, or condition that requires treatment by a physician. For a female member, illness includes childbirth or pregnancy. The term "illness," as used in this SPD, does not include mental illness or substance abuse, regardless of the cause or origin of the mental illness or substance abuse.
injury	Bodily damage from trauma other than illness, including all related conditions and recurrent symptoms.
inpatient	A person who is formally admitted to a hospital, skilled nursing facility, or inpatient rehabilitation facility and who occupies a hospital bed, crib, or bassinet while under observation, care, diagnosis, or treatment for at least a 24-hour confinement period.
intensive outpatient services	A program that provides 9 to 20 hours per week (less than 4 hours per day) of professionally directed evaluation and/or treatment.
jaw joint disorder (TMJ)	Any misalignment, dysfunction, or other disorder of the jaw joint (or of the complex of muscles, nerves, and tissues related to that joint). It includes temporomandibular joint (TMJ) dysfunction, arthritis, or arthrosis; other craniomandibular joint disorders; and myofascial or orofacial pain syndrome. It does not include a fracture or dislocation that results from an injury.
leave of absence	An approved absence without pay of more than 30 consecutive calendar days
living with you	A person living in your home at least 50% of the year. Stepchildren visiting for the summer are not considered to be living with you.

long-term disability terminees

An employee who has been approved for and is receiving disability benefits under Sandia's Long-Term Disability Plan or Sandia's Long-Term Disability Plus Plan.

maintenance care

Treatment beyond the point where material or significant improvement is to be expected. The treatment results in no measurable or objective improvement. For modality treatments, such as nonsurgical spinal treatment or physical therapy, the treatment provides no evidence of lasting benefit, only relief of symptoms.

medical director

The physician designated by CIGNA HealthCare with review/consultation responsibilities for medically related functions such as quality assurance programs, utilization review of care, and appeals of denied claims.

medical emergency

A sudden and unforeseeable injury or illness that arises suddenly, and in the judgment of a reasonable person requires immediate medical care and treatment, generally received within 24 hours of onset to avoid jeopardy to life or health.

medically necessary

Services or supplies ordered by a physician or provided by a hospital, physician, or other provider that the medical director or designee has determined are:

- Provided for the diagnosis or direct treatment of an injury or illness
- Appropriate and consistent with symptoms and findings or diagnosis and treatment of an injury or illness, and not experimental or investigative
- Provided in accordance with generally accepted medical practice on a national basis
- Not solely for the convenience of the member, plan physicians, or other health care plan provider
- The most appropriate supply or level of service that can be provided on a cost-effective basis including, but not limited to, inpatient versus outpatient care, electric versus manual wheelchair, surgical versus medical or other types of care
- Allowable under the provisions of this Plan as prescribed by the member's physician.

Important

The fact that a physician may provide, prescribe, order, recommend, or approve a service or supply does not in itself make the service or supply medically necessary or make the charge for it allowable even though the service or supply is not specifically listed as an exclusion in this Plan.

Medicare	A federal program administered by the Social Security Administration that provides benefits partially covering the cost of necessary medical care.
Medicare Allowable	For each procedure code, Medicare has its own allowed fee. If the provider accepts assignment with Medicare, the provider is required to write off any charges that are above their allowed amount. If the provider does NOT accept assignment, Medicare will apply their allowable fee to the charges and the patient is liable for the amount above Medicare's allowable fee up to Medicare's limiting charge (115% of Medicare's allowed amount).
Medicare eligible	The member is eligible to enroll in Medicare Parts A and B regardless of whether he or she enrolls.
Medicare primary	The member is eligible to receive Medicare benefits first before Sandia's plan is required to pay, regardless of whether the member enrolled in Medicare Parts A and B.
mid-year election change event	An event that allows a primary covered member to make certain changes to their health care coverage. Refer to the "Pre-Tax Premium Plan" booklet.
members	See "covered member."
morbid obesity	A condition in which an adult has been 100 pounds over normal weight (by the CIGNA HealthCare's underwriting standards) for at least five years despite documented unsuccessful attempts to reduce under a physician-monitored diet.
negotiated fees	A contractual fee agreed to by providers (see "participating provider") or facilities and the CIGNA HealthCare for service provided to CIGNA HealthCare members.
nonparticipating	Licensed provider or facility not contracted with or employed by CIGNA HealthCare.

nonsurgical spinal treatment

Detection or nonsurgical correction (by manual or mechanical means) of a condition of the vertebral column, including:

- distortion
- misalignment or
- subluxation

to relieve the effects of nerve interference that results from or relates to conditions of the vertebral column.

out-of-area coverage

Coverage provided for members whose residence is located outside of a 30-mile radius of a CIGNA-contracted provider. CIGNA HealthCare will determine who will be placed in the out-of-area plan.

out-of-pocket maximum

The covered member's financial responsibility for covered medical expenses before the Plan reimburses additional covered charges at 100% for the remaining portion of that calendar year.

outpatient

A person who visits a clinic, emergency room, or health facility and receives health care without being admitted as an overnight patient (under a 24-hour stay).

outpatient surgery

Any invasive procedure performed in a hospital or surgical center setting when a patient is confined for a stay of less than 24 consecutive hours.

outpatient surgery facility

A facility that is either freestanding or associated with a hospital or physician's office that is permanently equipped to perform surgery without requiring an overnight stay.

partial hospitalization

A program that provides covered services to persons who are receiving professionally-directed evaluation or treatment and who spend only part of a 24-hour period (but at least four hours per day) or 20 hours per week in a hospital or treatment center.

participating provider

The health care professionals, hospitals, facilities, institutions, agencies, and practitioners contracted with CIGNA HealthCare to provide covered services and supplies to CIGNA HealthCare members.

physicians

Any of the following licensed practitioners who perform a service payable under this Plan:

- A doctor of medicine (MD), osteopathy (DO), podiatry (DPM), or chiropractic (DC)
- A licensed doctoral, clinical psychologist
- A Master's-level counselor and licensed or certified social worker who is acting under the supervision of a doctor of medicine or a licensed doctoral, clinical psychologist
- A licensed physician's assistant (PA)
- A licensed nurse practitioner
- Where required to cover by law, any other licensed practitioner who:
  - Is acting within the scope of his/her license
  - Performs a service that is payable under this Plan.

A physician eligible for reimbursement by the Plan does not include a person who lives with you or is part of your family (you, your spouse, or a child, brother, sister, or parent of you or your spouse).

Plan Sponsor

Sandia Corporation

post-secondary educational program

Students who are classified as Graduate, Professional, Administrative or Co-op; Graduate Engineering Minorities; Undergraduate Co-op, General Clerical, Technical or Business; and General Laborer.

pre-certification

The process whereby the member calls CIGNA HealthCare to obtain prior approval for medical necessity and length of any hospital confinement.

Pre-Tax Premium Plan

A Plan that allows employees to pay premiums on a pre-tax basis.

primary care physician	The physician who coordinates and manages your total health care for routine physicals and hospitalizations, ensuring that you receive the most appropriate care for your medical needs. Your PCP may practice in family practice or internal medicine. Pediatricians and OB/GYN physicians are also considered those patients' PCP.
primary covered member	The person for whom the coverage is issued, that is, the Sandia employee, retiree, survivor, or the individual who is purchasing temporary continued coverage.
primary plan/coverage	The plan that has the legal obligation to pay first when more than one health care plan is involved.
prior approval	See "prior authorization."
prior authorization	Certain services require prior authorization from the Health Services Department at CIGNA HealthCare. Prior authorization is based upon clinical findings supporting medical necessity and benefit determination. The clinical information provided to the Health Services Department aids in the medical review throughout the treatment.
providers	See "physicians."
qualified beneficiary	An employee, spouse, or dependent covered the day before the qualifying event, to include a child who is born to or placed for adoption with the covered member during COBRA. Qualified beneficiaries must be given the same rights as similarly situated employees, retirees, and their families.
qualifying event	Under COBRA, an event that but for the COBRA requirements would result in the loss of coverage to a qualified beneficiary.

Qualified National Medical Support Notice (QNMSN)

The federal government mandates that all states use this standardized form to notify an employer to withhold premiums from an employee's income when a parent is ordered to provide health care coverage for his or her child(ren). The QNMSN is the notice employers receive from the state child support enforcement agency instructing them to enroll a child(ren) in available dependent health coverage. The QNMSN helps ensure children receive health care coverage when it is available and required as part of a child support order. It is designed to simplify the work of employers and plan administrators by providing uniform documents requesting health care coverage.

Qualified Medical Child Support Order (QMCSO)

Upon receiving the QNMSN packet the employer determines if the state agency has correctly completed the notice and if it meets the requirements for a Qualified Medical Child Support Order (QMCSO) under ERISA. To be "qualified" a medical support order must clearly specify:

- the member's name and last-known address
- the name and address of each child covered by the order
- a reasonable description of the coverage to be provided, or the manner in which coverage will be determined
- the period for which the order applies.

If the QNMSN lacks any of the required information, but that information is reasonably available to the employer, the employer should consider the QNMSN qualified and proceed with enrolling the child(ren) in the medical plan. If the information is not available, the employer will return the QNMSN to the issuing agency.

reconstructive procedure

A procedure performed to address a physical impairment where the expected outcome is restored or improved function. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as reconstructive procedure.

service area	The geographical area, approved by the appropriate staff agency, within which participating providers are accessible to members.
short-term counseling	For Sandia's EAP, one to eight problem assessment/counseling visits per member per calendar year. Individuals or dependents/families may access the visits separately if different problems are addressed.
skilled nursing care facility	An institution or that part of an institution that provides convalescent or nursing care and is, or could be, certified as a skilled nursing care facility under Medicare.
sound natural teeth	Teeth that: • are whole or properly restored • are without impairment or periodontal disease • are not in need of the treatment provided for reasons other than dental injury.
specialist	A physician who provides specialty services such as a dermatologist, podiatrist, cardiologist, etc.
subrogation	The Plan's or CIGNA HealthCare's right to recover any Plan payments made because of illness or injury to you or your dependent caused by a third party's wrongful act or for negligence and for which you or your dependent have a right of action or later recovered said payments from the third party.
substance abuse	Abuse by the individual of drugs, alcohol, or other chemicals to the point of addiction, which has been diagnosed as an illness by a licensed physician.
total disability or totally disabled	Because of an injury or illness: • You are completely and continuously unable to perform the material and substantial duties of your regular occupation and are not engaging in any work or occupation for wages or profit

- Your dependent is:
    - either physically or mentally unable to perform all of the usual duties and activities (the "normal activities" of a person of the same age and gender who is in good health)
    - not engaged in any work or occupation for wages or profit.

urgent care	Care provided for non-life-threatening medical events that require prompt medical attention: sprains, strains, vomiting, cramps, diarrhea, bumps, bruises, colds, fevers, small lacerations, minor burns, severe stomach pains, swollen glands, rashes, poison ivy, back pain, etc.
urgent care facility	Can be attached to a hospital or be freestanding, staffed by licensed physicians and nurses, and providing health care services.
urgent care services	Treatment of a sudden or severe onset of illness or injury.
usual and customary charges	The global charge for a covered service or supply that is no higher than the 90th percentile of CIGNA's most currently available prevailing health care charge data. CIGNA uses the 90th percentile of physician charges in the geographic area as the U&C allowable.
utilization management/ review	A process used to review whether health care services are medically necessary and the most beneficial to your care.

Appendix B. Members Rights and Responsibilities

One of CIGNA HealthCare's goals is to work in cooperation with participating ***physicians*** to provide you with access to quality care and programs. The CIGNA HealthCare Quality Management Program is based on industry standards and objective measures that help CIGNA HealthCare evaluate the quality of care and services received by CIGNA HealthCare ***members***. The program also helps CIGNA HealthCare better focus their improvement efforts. The Quality Management Program allows for input from ***members*** and ***providers*** through regular analysis.

You may contact CIGNA HealthCare at the address or telephone number on your CIGNA HealthCare ***ID*** card with your opinions, ideas, and thoughts. Your participation in plan surveys gives direct feedback on plan performance and policy development.

You Have a Right to:

- Medical treatment that is available when you need it and is handled in a way that respects your privacy and dignity.
- Get the information you need about your health care plan, including information about services that are covered, services that are not covered, and any costs that you will be responsible for paying.
- Have access to a current list of ***providers*** in the CIGNA HealthCare network and have access to information about a particular ***provider's*** education, training, and practice.
- Have your medical information kept confidential by CIGNA HealthCare employees and your health care provider. Confidentiality laws and professional rules of behavior allow CIGNA HealthCare to release medical information only when it's required for your care, required by law, necessary for the administration of your plan, or to support CIGNA HealthCare programs or operations that evaluate quality and service. We may also summarize information in reports that do not identify you or any other participants specifically.
- Have your health care provider give you information about your medical condition and your treatment options regardless of benefit coverage or cost. You have the right to receive this information in terms you understand.
- Learn about any care you receive. You should be asked for your consent for all care, unless there is an ***emergency*** and your life and health are in serious danger.
- Refuse medical care. If you refuse medical care, your health care provider should tell you what might happen. We urge you to discuss your concerns about care with your doctor. Your doctor will give you advice, but you will always have the final decision.

- Be heard. CIGNA HealthCare's complaint-handling process is designed to hear and act on your complaint or concern about CIGNA HealthCare and/or the quality of care you receive, provide a courteous, prompt response, and to guide you through CIGNA HealthCare's grievance process if you do not agree with CIGNA HealthCare's decision.
- Make recommendations regarding CIGNA HealthCare's policies on ***member*** rights and responsibilities. If you have recommendations, please contact CIGNA HealthCare's ***Member*** Services at the toll-free number on your CIGNA HealthCare ***ID*** card.

You Have the Responsibility to:

- Review and understand the information you receive about your health care plan. Call CIGNA HealthCare when you have questions or concerns.
- Understand how to use CIGNA HealthCare services.
- Show your CIGNA HealthCare ***ID*** card before you receive care.
- Schedule a new patient appointment with any new CIGNA HealthCare network provider, build a comfortable relationship with your doctor, ask questions about things you don't understand, and follow your doctor's advice. You should also understand that your condition may not improve and may even get worse if you don't follow your doctor's advice.
- Understand your health condition and work with your doctor to develop treatment goals that you both agree upon to the extent that this is possible.
- Provide honest, complete information to the ***providers*** caring for you.
- Know what medicine you take, why, and how to take it.
- Pay all payments for which you are responsible, at the time service is received.
- Keep scheduled appointments and notify the doctor's office ahead of time if you are going to be late or miss an appointment.
- Pay all charges for missed appointments and for services that are not covered by your plan.
- Voice your opinions, concerns, or complaints to CIGNA HealthCare and/or your provider.
- Notify Sandia Benefits, as soon as possible, about any changes in family size, address, phone number, and coverage status.

Appendix C. Member Discounts

Sandia National Laboratories is providing the following discount programs information strictly as a convenience to CIGNA HealthCare ***members***. Sandia cannot guarantee any discounts, results, or performance for the following programs:

CIGNA HealthCare Healthy Rewards®—provides discounts for ***members*** from ***participating providers*** including:

- Weight Watchers
- QuitNet® and Tobacco Solutions™ smoking cessation programs
- 10,000 Steps exercise programs
- Chiropractic care
- Magazine discounts
- Optical shop
- Eye exams, frames, and lenses
- Laser vision correction
- Hearing care
- Acupuncture
- Anti-cavity products
- Curves®

Some programs may not be available in all states. A discount program is not insurance and the participant is required to pay the provider the entire amount minus the applicable discount provided through the Healthy Rewards®. You can locate providers participating in your area by logging into www.mycigna.com or by calling 1-800-870-3470.

Appendix D. Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule

Effective April 14, 2003, a federal law known as the Health Insurance and Portability and Accountability Act of 1996 (***HIPAA***) requires that health plans protect the confidentiality of private health information. A complete description of your rights under ***HIPAA*** can be found in the Plan's privacy notice.

This Plan and Sandia Corporation will not use or further disclose information that is protected by ***HIPAA*** ("protected health information") without your written authorization except as necessary for treatment, payment, health plan operations, and plan administration, or as permitted or required by law. By law, the Plan requires all of its business associates to observe ***HIPAA's*** privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit plan of Sandia National Laboratories.

Under ***HIPAA***, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, to receive an accounting of certain disclosures of the information and, under certain circumstances, to amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under ***HIPAA*** have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under ***HIPAA's*** privacy rules. Privacy notices are distributed to all new ***members*** in the Plan and are distributed to current ***members*** under a scheduled timetable regulated by ***HIPAA***. In addition, a copy of this notice is available upon request by contacting the Sandia ***HBES*** at (505) 844-4237.

If you have questions about the privacy of your health information or you wish to file a complaint under ***HIPAA***, please contact the ***HIPAA*** Officer in the Benefits Office.