

## Class II Dependent Medical Plan Coverage Information

*Included in this packet:*

- Class II Dependent Eligibility Requirements (p. 1)
- Premiums (p. 1)
- Enrollment Instructions (p.1)
- Class II Dependent Affidavit (p. 4-5)
- Premium Deduction Authorization (p. 6)

### Eligibility Requirements:

*Your Class II Dependent(s) may include your:*

- unmarried child or step-child who is not eligible as a Class I dependent,
- unmarried grandchild,
- unmarried brother or sister,
- parent, step-parent, or grandparent or your spouse's parent, step-parent or grandparent.

*To qualify for coverage, you must be enrolled in the UHC Premier PPO, UHC Standard PPO, and CIGNA Premier PPO Plans only.*

*To qualify for medical coverage, a Class II Dependent must:*

- Be financially dependent on you; **and**
- Have lived in your home, or one provided by you in the United States, for the most recent six months; **and**
- Have total income from all sources of less than \$15,000/year other than the support you provide.

### Monthly premiums for Class II Dependents are as follows:

#### 2007

Non-Medicare Class II dependents of <b>Employees:</b> -\$223 / month for the UHC Standard PPO Plan -\$263 / month for the UHC Premier PPO Plan -\$263 / month for the CIGNA Premier PPO Plan	Non-Medicare Class II dependents of <b>Retirees:</b> -\$324.36 / month for the UHC High Deductible Health Plan -\$383.52 / month for the UHC Premier PPO Plan -\$383.52 / month for the CIGNA Sr. Premier PPO Plan
Medicare Class II dependents of <b>Employees:</b> -\$141 / month for the UHC Sr. Premier PPO Plan -\$140 / month for the CIGNA Sr. Premier PPO Plan	Medicare Class II dependents of <b>Retirees:</b> -\$141 / month for the UHC Sr. Premier PPO Plan -\$140 / month for the CIGNA Sr. Premier PPO Plan

#### 2008

Non-Medicare Class II dependents of <b>Employees:</b> <b>Employees:</b> -\$227 / month for the UHC Standard PPO Plan -\$267 / month for the UHC Premier PPO Plan -\$267 / month for the CIGNA Premier PPO Plan	Non-Medicare Class II dependents of <b>Retirees:</b> <b>Retirees:</b> -\$330.48 / month for the UHC High Deductible Health Plan -\$389.64 / month for the UHC Premier PPO Plan -\$389.64 / month for the CIGNA Sr. Premier PPO Plan
Medicare Class II dependents of <b>Employees:</b> -\$158 / month for the UHC Sr. Premier PPO Plan -\$156 / month for the CIGNA Sr. Premier PPO Plan	Medicare Class II dependents of <b>Retirees:</b> -\$158 / month for the UHC Sr. Premier PPO Plan -\$156 / month for the CIGNA Sr. Premier PPO Plan

Premiums are subject to increase annually, based on Sandia's changing medical plan costs. For active Sandia employees, deductions for coverage may be taken on a pre-tax or after-tax basis (payroll deductions only).

### How to Enroll:

- **On-roll employees:** To enroll your Class II dependent, you must complete the Class II Dependent Application, Class II Dependent Affidavit, and Premium Deduction Authorization (all included in this document) and return them to the Benefits Customer Service Center, MS 1463 **within 31 calendar days of the qualified change in status.**
- **Retirees:** To enroll your Class II dependent, you must complete a Class II Dependent Application and Class II Dependent Affidavit. Both the Application and Affidavit should be returned to the Benefits Customer Service Center, MS 1463 **within 31 calendar days of the qualified change in status.** The premium will be deducted from your pension check.

If enrolling a newborn child, the Benefits Customer Service Center (505-844-4237), **must be notified within 31 calendar days of the birth to obtain coverage** for the newborn's expenses incurred during the delivery. The premium for a newborn baby is prorated from the day of the birth for the first month's premium.

### Other information regarding Class II dependent(s):

- Class II dependents are NOT eligible for chemical dependency rehabilitation benefits
- All Class II dependents who are eligible for Medicare must enroll in Part A and Part B
- Your Class II dependent will be covered (if they meet the eligibility requirements) beginning the first day of the month following their enrollment
- If you wish to cancel coverage, contact the Benefits Customer Service Center and request a Premium Deduction Cancellation form.

### For more information contact:

Benefits Customer Service Center (Dept. 3332)  
505-844-4237  
MS 1463





Operated for the U.S. Department of Energy by

**Sandia Corporation**

Albuquerque, NM 87185-1463

Phone: (505) 844-4237

Fax: (505) 844-7535

**Sandia National Laboratories**  
**Benefits Department, 3332**  
**PO Box 5800, MS 1463**  
**Albuquerque, New Mexico 87185-1463**  
**505 844-4237**

## Class II Dependent Affidavit

---

*To be completed by the employee/retiree and submitted to the Sandia Benefits Customer Service Center at the address above. Please keep a copy for your records.*

### Sworn Affidavit

I, (Employee/Retiree – PRINT NAME)

do hereby certify and declare under the penalties of perjury that the below named Class II dependent meets the following criteria and is eligible under the rules of the Sandia benefits program.

(Class II Dependent - PRINT NAME)

### The above named Class II Dependent meets one of the following criteria:

- unmarried child who is not eligible as a Class I dependent
- unmarried step-child who is not eligible as a Class I dependent
- unmarried grandchild
- unmarried brother or sister
- parent or grandparent or your spouse's parent or grandparent
- step-parent or your spouse's step parent

### Meets the following additional criteria:

- is financially dependent on me by receiving greater than 50% of their support from me.
- has a total income from all sources of \$15,000 or less per year other than the support I provide.
- Has lived in my home or a home provided by me in the United States for the most recent 6 months

### Change in Dependent Status

I agree to provide notification when and if there is any change in the status of my Class II dependent. When the status as Class II dependent as described under oath in this *Affidavit* changes in any way to render the dependent ineligible for the Sandia Laboratories benefits program (for example, change in marital status, financial status and/or changes occur in my provision of a residence for the dependent), or any other changes occur which then make it impossible for us to truthfully complete and execute this same sworn affidavit.

I will provide notification within 31 days of any change in the status of my Class II Dependent. Coverage under the Sandia Corporation benefits program will be terminated as of the date we no longer meet the criteria listed above.

*Class II Dependent Affidavit (continued)*

**Acknowledgements**

I understand that any person/employer/insurer/claims administrator (including Sandia and its third party plan administrators) who suffers any loss due to any false statement contained in this *Affidavit* may bring civil action against me to recover their losses, including reasonable attorney's fees.

I have provided the information in this *Affidavit* for the sole purpose of enabling Sandia to determine our eligibility for Class II dependent benefits. I understand that this information will be held confidential from disclosure outside Sandia, treated in accordance with all applicable federal and state regulations and will be subject to disclosure outside Sandia only upon our express written authorization, pursuant to a court order or legitimate governmental demand for such information from the Internal Revenue Service or a state or federal labor law enforcement agency, or if there is another compelling and legitimate business need to provide access to the information.

I declare, under penalties of perjury, that the statements in this *Affidavit* are true to the best of my knowledge. I understand that this form is not an application for benefits coverage and that the purpose for this form is to establish the eligibility of person named herein as a Class II dependent for the coverage provided under the Sandia Corporation benefits program.

Please complete this form and return it, along with the required documentation to the following address:

**Sandia National Laboratories  
Benefits Department, 3332  
PO Box 5800, MS1463  
Albuquerque, New Mexico 87185-1463**

Please keep a copy of this completed form for your records.

*To be signed in presence of Notary Public:*

\_\_\_\_\_  
Signature of Employee/Retiree

Employee/Retiree SNL I.D.:
Street Address:
City, State ZIP:

*For use by Notary Public:*

City of _____
County of _____
Sworn before me _____, this _____
day of _____, 20_____.
Notary Public _____
My Commission Expires _____, 20_____.

## Medical Care Plan – Class II Dependents Premium Deduction Authorization

---

Last Name:
First Name & M.I.:
SNL I.D.:
I wish to insure my eligible dependents as Class II Dependents.
I authorize Sandia National Laboratories to deduct the appropriate premium from my biweekly paycheck to cover the cost of this insurance.*
Employee's Signature: _____
Date:    /    /    (mm/dd/yyyy)

Please complete this form and return it, along with the required documentation to the following address:

**FAX: (505) 844-7535**  
**Alternatively, mail to:**  
**Sandia National Laboratories**  
**Benefits**  
**PO Box 5800, MS1463**  
**Albuquerque, New Mexico 87185-1463**

**Please keep a copy of this completed form for your records.**