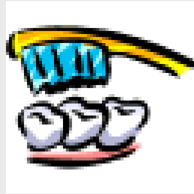
A Department of Energy National Laboratory

Dental Expense Plan

and

Dental Deluxe Plan



DEP

and

DDP

Summary Plan Description

Effective: January 1, 2004

SAND 2004-2783 W

Dental Expense Plan

and

Dental Deluxe Plan

The **Dental Expense Plan** (DEP) is designed to promote good dental health by providing coverage for a broad range of dental services and supplies.

There is also an optional plan, the **Dental Deluxe Plan** (DDP), that provides additional coverage for a monthly premium. The DDP became effective January 1, 1996. Information on the DDP is available in the last chapter of this booklet.

This booklet is a Summary Plan Description and is provided in accordance with the requirements of the Employee Retirement Income Security Act (ERISA) of 1974 and the Internal Revenue Code. This Summary Plan Description summarizes operations, benefits, claim filing procedures, and other Plan provisions. More detailed information is contained in the official DEP and DDP documents, which govern the operation of the DEP and DDP. Copies of these documents are available from your Sandia Corporation (Sandia) Benefits Department.

The DEP and the DDP are maintained at the discretion of Sandia. They are not intended to create a contract of employment and do not change the at-will employment relationship between you and Sandia. The Sandia Board of Directors (or designated representative) reserves the right to suspend, change, or amend any or all provisions of the DEP or the DDP, and to terminate the DEP or the DDP at any time without prior notice, subject to applicable collective bargaining agreements. If the DEP and/or DDP 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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Dental Expense Plan

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DEP Highlights

Summary of Plan Changes

This section contains a brief description of changes that have been implemented since the previous Dental Expense Plan and Dental Deluxe Plan Summary Plan Description (SPD) dated January 1, 2002.

- Eligibility has been changed to include qualifying same-gender domestic partner dependents (nonrepresented employees and OPEIU- and SPA-represented employees only.)
- Dental procedure codes in Appendix A have been updated to reflect American Dental Association code revisions.
- For MTC- and OPEIU-represented employees and retirees, the eligibility requirement for unmarried children age 19 and over, but under age 24, changed from financially dependent and full-time student attending an institution of learning to financially dependent only.
- For MTC- and OPEIU-represented employees and former MTC- and OPEIU-represented retirees, the Dental Expense Plan (DEP) reimbursement schedule has been adjusted to reflect the current costs of the dental administrator, Delta Dental, for covered restorative services. The Dental Deluxe Plan (DDP) reimbursement schedule will reflect coverage at approximately 25% more than the DEP schedule.

Customer Service Contacts

Delta Dental is the Claim Administrator for Sandia's DEP and DDP. Dental plan questions may be directed to any of the following customer service telephone numbers:

Delta Dental	800-264-2818
Sandia Benefits Customer Service Center (Albuquerque)	505-845-2363 or 800-417-2634, then dial 845-2363
Sandia Benefits Department (Livermore)	925-294-2254

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Basic Provisions

Purpose of the DEP

The Dental Expense Plan (DEP) is designed to promote good dental health by providing coverage for a broad range of dental services and supplies.

Cost of the DEP

The cost of the DEP is paid in full by Sandia for eligible participants except for the following groups, who pay for part or all of their coverage:

- Part-time employees who are scheduled to work 20 hours per week,
- Some retirees (see page 43),
- Some persons on leave of absence (LOA) (see page 43), and
- Individuals who temporarily continue their coverage after an event that would normally cause termination of coverage (see page 44).

Choice of Dentists

Covered participants retain full freedom of choice of dentists. You may select a network dentist or a nonnetwork dentist each time you need a dental procedure.

For information regarding network dentists, see the Network (Participating) Providers section, page 23.

Payment of Benefits and Deductibles

The Claim Administrator will make the following payment of benefits for Type A and Type B services:

- **Type A services**—The DEP pays 100% of usual and customary (U&C) charges (see definition in Appendix B). For a list of Type A services, see Type A: Diagnostic and Preventive Services, page 14. Type A services are not subject to a deductible, but may be subject to sales tax. The participant, not the Plans, is responsible for paying the sales tax if it is billed as a separate item.

- **Type B services**—The DEP pays according to a reimbursement schedule (Appendix A, Chart II). For a list of Type B services, see Type B: Other Covered Services, page 15. Type B services are subject to a $25 **annual deductible** for each covered participant.

IMPORTANT **The dollar amounts in the Appendix A Reimbursement Schedules are the amounts the DEP will pay for a particular procedure. Reimbursements may be modified by coordination of benefits or may be prorated depending on the extent of the procedure.**

The DEP reimburses a maximum of $1500 in a calendar year for each covered participant in your family for **covered nonorthodontic expenses**. There is no lifetime maximum.

The DEP reimburses a **lifetime** maximum of $1500 for each covered participant in your family for **covered orthodontic expenses**. This maximum is separate and distinct from the DEP $1500 calendar year maximum for covered nonorthodontic expenses.

It is recommended that you obtain a predetermination of benefits for all expenses that exceed $200. See Predetermination of Benefits, page 25, for more information.

ERISA Information

As a participant in the 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 in your Employee Benefits binder and is entitled ERISA Information.

Note: For retirees, the ERISA Information booklet is mailed separately or may be obtained by contacting the Sandia Benefits Customer Service Center (BCSC).

Plan Information

The Dental Expense Plan (DEP) is a self-insured plan for eligible participants (as defined in this booklet) of Sandia National Laboratories, P. O. Box 5800, Albuquerque, NM, 87185 (Employer Identification Number 85-0097942).

Delta Dental, the Claim Administrator, has assigned the following group plan number: **9550**. For information concerning service of legal process, contact the Sandia Legal Division, Sandia National Laboratories, P. O. Box 5800, MS 0141, Albuquerque, NM, 87185.

The 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.

Eligibility

Employees Eligible for Coverage

You are eligible to be a **covered participant** in the DEP if you meet one of the following criteria:

- You are a regular full- or part-time employee (as classified by Sandia for payroll purposes).
- You are a nonregular full- or part-time employee (as classified by Sandia for payroll purposes) in the limited term employee, post-doctoral appointee, or the full-time, year-round faculty sabbatical appointee classifications.

Note: Full-time, year-round faculty sabbatical employees must not be eligible for other group dental coverage to be eligible for this Dental Plan.

- You are a retired employee.
- You are a covered employee on certain approved leaves of absence.

IMPORTANT **You are also eligible for coverage after an event that would normally cause termination of coverage if you elect and pay for temporary continued coverage as described in the Continuation and Conversion chapter.**

Eligible Dependents

Dependents of covered participants (employees and other eligible persons) are eligible to participate in the DEP. Your eligible dependents include your:

- Spouse, not legally separated or divorced from the covered participant;
- Unmarried child under age 19 (see Appendix A for definition of "child");
- Unmarried child age 19 and over, but under age 24 who is financially dependent on you; and
- Unmarried child of any age, who, because of a physical handicap or mental impairment, including mental illness:
  - Is incapable of self-sustaining employment,

- Lives with you (the covered participant) or in an institution or in a home you provide, **and**
- Is financially dependent on you, the covered participant.

- Domestic partner who meets all of the following criteria:
  - Must be a domestic partner of a nonrepresented, OPEIU- or SPA-represented employee (retirees and other employees are not eligible to enroll domestic partners and/or domestic partner dependents),
  - Is the same gender as the employee,
  - Shares significant financial resources and dependencies,
  - Has resided with the employee continuously for at least six months in a sole-partner relationship that is intended to be permanent,
  - Is unmarried,
  - Is not related to employee by blood (e.g., brothers, sisters, parents, children, cousins, nieces, uncles),
  - Is at least 18 years of age, and
  - Has complied with all Sandia requirements for verification of domestic partner eligibility.

  Note: Contact the Sandia BCSC at 505-845-2363 to request the enrollment packet or go to Sandia's Domestic Partner webpage at http://www-irn.sandia.gov/hr/benefits/domesticpartner/ index.htm for the packet, which contains information on enrolling domestic partner dependents, including affidavit and enrollment forms, documentation requirements, and tax implications.

- Unmarried child of your domestic partner under age 19 (see Appendix B for definition of "child");
- Unmarried child of your domestic partner age 19 and over, but under age 24 who is financially dependent on you; and
- Unmarried child of your domestic partner of any age, who, because of a physical handicap or mental impairment, including mental illness:
  - Is incapable of self-sustaining employment,
  - Lives with you (the covered participant) or in an institution or in a home you provide, **and**
  - Is financially dependent on you, the covered participant.

IMPORTANT **The covered participant must notify the Sandia BCSC within 31 calendar days of a mid-year election change event. Refer to the Pre-Tax Premium Plan booklet for information on mid-year election change events.** **See Effective Date of Coverage, page 11.**

Notify the Sandia BCSC within 31 calendar days of the following changes in dependent eligibility:

- Newly acquired dependents;
- A child age 19 or over who becomes eligible because of a physical or mental impairment she/he has, and meets the qualifications as described above; or
- Dependents who become ineligible for coverage.

Disenrolling Dependents

The following rules apply to retirees, those employees who are having a dental premium deducted from their paychecks on an **after-tax basis**, and those employees who are not paying a premium.

IMPORTANT **For rules regarding disenrolling dependents under the Pre-Tax Premium Plan (for employees only), refer to the Pre-Tax Premium Plan Booklet.**

If you have a dependent who loses eligibility, please notify the Sandia BCSC as soon as the dependent loses eligibility. All Class I dependents must be disenrolled with the Sandia BCSC **within 31 calendar days** of the mid-year election change event causing ineligibility. The effective date of disenrollment will be the last day of the month in which the dependent becomes ineligible.

If you fail to disenroll your dependent within 31 days, upon notification to the Sandia BCSC at 505-845-BENE (2363), Sandia will

- Retroactively terminate coverage,
- Refund any applicable premium paid by you, and
- Consider disciplinary action for fraudulent use of the Plan.

If notification is not done in a timely manner, you could lose any rights to temporary continued coverage under COBRA.

You will be responsible for any claims incurred after your dependent loses eligibility and for reimbursement of any claims paid by the Plan.

Note: You may also disenroll a dependent without a mid-year election change event if you are NOT enrolled in the Pre-Tax Premium Plan.

How to Disenroll a Dependent

To disenroll a dependent:

- Complete a Dental and Vision Care Plan Disenrollment Form,
- Retain a copy for your files, and
- Mail the original to the Sandia BCSC at MS 1022.

Forms are available from the Sandia BCSC at 505-845-BENE (2363) or on the Web under Corporate Forms.

Sandia abides by a federal law referred to as the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1987 in which temporary continued coverage is provided to dependents who would otherwise lose group coverage due to specified events. Refer to Continuation and Conversion, page 43, for more information.

Persons Excluded from Coverage

Nonregular employees—Certain classifications of nonregular employees are **not** eligible. Examples are:

- Summer (or other than full-time, year-round) faculty sabbatical employees,
- Student interns, and
- Recurrent employees.

Terminated participants—Terminated participants who have **not** chosen temporary continued coverage (see page 44) or who have exhausted this coverage are not eligible.

Examples are:

- A person who became disabled before retirement and is eligible to receive Sandia Long-Term Disability Plan benefits.
- A surviving spouse of a covered employee or retiree.

Class II Dependents—The Plan specifically excludes dependents referred to in the Top PPO, Intermediate PPO, and Basic PPO Medical Plans as Class II dependents. Examples of these dependents are grandchildren (for whom you are **not** the legal guardian), brothers, sisters, parents, and grandparents.

Dual Coverage-Employee/Dependent—Under the Plan, you cannot be covered as both a dependent and a Sandia employee, or as a dependent of more than one Sandia employee.

Effective Date of Coverage

Employees—Coverage begins on the day you report for active employment with Sandia.

Dependents—Coverage for dependents becomes effective on the latter of:

- The date of effective coverage for the employee, or
- The date of the mid-year election change event affecting dependent eligibility, or
- The date written notification is received by the Benefits Department to enroll a dependent due to a mid-year election change event.

Note: If enrolling a dependent due to a birth, adoption, or placement for adoption, the coverage becomes effective on the date of the birth, adoption, or placement for adoption. You must enroll the dependent within 31 calendar days.

Note: Adopted dependents become eligible as of the placement date as shown on the adoption agreement.

IMPORTANT **If you fail to enroll your dependent within 31 calendar days, you must wait until the next Open Enrollment period to enroll the dependent for coverage to be effective the following calendar year.**

Employees Returning from LOA—Coverage for employees returning to work immediately following an approved LOA, whose coverage ceased during such leave, will be effective on the day of reinstatement.

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 participant (as defined by ERISA) who is recognized as an alternate recipient in a Qualified Medical Child Support Order (QMCSO). This Plan will comply with the terms of a QMCSO. A QMCSO is an order or judgment from a court or administrative body directing the Plan to cover a child of an eligible participant under a group health plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected eligible participant and each child (or the child's representative) who is covered by the order will be given notice of the receipt of the order. The Sandia Legal Division will review the order and notify you within 40 business days of the date of notice to Sandia of their review. Coverage under the Plan pursuant to a QMCSO will not become effective until the Plan Administrator determines that the order is a QMCSO. If you have any questions or would like to receive a copy of the written procedure for

determining whether a QMCSO is valid at no charge, please contact the Sandia BCSC at 505-845-BENE (2363).

Questions

Contact the Sandia BCSC at 505-845-BENE (2363) if you have any questions about eligibility.

Eligibility Appeal Procedures

If Delta Dental denies your or a dependent's claim because of eligibility, you may contact the Sandia BCSC at 845-BENE (2363) to request a review of eligibility status. Written notification will be sent to you informing you of the decision within three business days of your request. If you are not satisfied with the decision, you may request that your or your dependent's eligibility status be reviewed by the Employee Benefits Committee (EBC), which you must do in writing within 180 calendar days of the date of the letter informing you of the decision. The EBC has the exclusive right to interpret and apply the eligibility provisions of this Plan and to construe its terms to determine member eligibility thereunder; however, the determination of a dependent (due to a physical or mental impairment) for the purpose of determining eligibility under the Plan is the responsibility of the Claim Administrator who administers the medical plan you are enrolled in. The determination of the EBC is conclusive and binding. You will be informed of the EBC's decision in writing within 60 calendar days of the date the appeal was received; however, the EBC can request an additional 60 days if special circumstances apply. You must exhaust the appeals process before you pursue any legal recourse.

Coverage

This chapter describes the type and frequency of dental services covered under the DEP and furnishes examples of coverage/reimbursement amounts. Dental services are categorized as Type A and Type B. For those employees who opt for the Dental Deluxe Plan (DDP), the dental services covered are the same (with the exception of sealants for children under the age of 14), but the reimbursement rates are higher. Refer to the Dental Deluxe Plan chapter for more information.

Type A services are diagnostic and preventive procedures.

Type B services include any other procedures that are primarily restorative.

Refer to Appendix A for the dollar amount that the DEP and the DDP will reimburse for Type B services. All examples in this chapter refer to the DEP unless otherwise stated. These services are categorized by the procedure codes that are standardized by the American Dental Association.

Maximum Benefits

Reimbursements for covered Type A and B expenses are for up to $1500 for a calendar year for nonorthodontic covered expenses, and for a $1500 **lifetime** maximum for orthodontic expenses after the applicable deductible has been met. Example 4 under Examples of Covered Expenses, page 18, shows how the maximums can affect reimbursement. The lifetime maximum for orthodontic expenses is separate and distinct from the calendar-year maximum for covered Type A and B expenses.

Type A: Diagnostic and Preventive Services

The following Type A diagnostic and preventive services are covered at 100% of U&C charges.

Service	Limited to. . .
■ Routine oral exams to diagnose the oral health of the patient and to determine the dental care required	Two exams in any calendar year
■ Prophylaxis (cleaning and scaling of teeth) performed by a dentist or dental hygienist	Two prophylaxes in any calendar year
■ Fluoride treatments (excluding prophylaxis) performed by a dentist or dental hygienist, to include	
– local application of sodium fluoride, or	One treatment (four applications) in any calendar year
– local application of stannous fluoride, or	One treatment in any calendar year
– local application of acid fluoride phosphate	One treatment in any calendar year
■ Space maintainers (eligible dependents under age 19 only), to include	
– installation of fixed or removable appliances designed to maintain existing space by preventing adjacent or opposing teeth from moving	Only when these appliances replace prematurely lost or extracted teeth
– later adjustment of these appliances because of a relative change in the condition of the mouth	No limit
■ X-rays (dental x-rays, radiographs), to include	
– full-mouth x-rays	No more than once every three years
– supplementary bitewing x-rays	Twice in a calendar year
– periapical and/or panorex dental x-ray required to diagnose a specific condition that needs treatment, except x-rays in conjunction with orthodontic treatment	No limit
■ Sealants	Not covered under the DEP (for coverage under the DDP, refer to page 57).

Type B: Other Covered Services

The following Type B services are reimbursed (after the $25 **annual** deductible) according to the Reimbursement Schedule for Common Type B Procedures in Appendix A, Chart II, or in Appendix A, Chart III, if you have opted for the DDP.

- **Restorations,** including fillings, inlays, onlays, and crowns needed to restore the structure of a tooth to a state of functional acceptability after cavity or fracture.
- **Oral surgery** such as extractions.
- **Endodontic procedures** such as root canal work used to prevent and treat diseases of the dental pulp.
- **Periodontic surgical and nonsurgical procedures** to treat the supporting area around the teeth.
- **Prosthodontic** services to replace one or more teeth extracted **while the patient is covered under the DEP,** to include the following, but **excluding** wisdom teeth:
  - First installation of fixed bridgework, including inlays and crowns, to form supports.
  - First installation of partial or full removable dentures, including adjustments during the first six months after they are installed.
  - Addition of teeth to existing partial removable dentures or to bridgework.
  - Installation of a permanent full denture that replaces a temporary denture and is installed within 12 months of the temporary denture.
  - Repairing or recementing inlays, crowns, bridgework, and dentures.
  - Relining dentures.
  - Replacement of an existing partial denture, full removable denture, or fixed bridgework, *provided the existing denture or bridgework cannot be made serviceable and that it was installed at least five years before its replacement.*

  Note: Five years of coverage or employment are not necessary; the only requirement is that the old appliance be at least five years old. But, if additional extractions require the replacement of dentures or bridgework, the five-year requirement is waived.
- **Orthodontic services** for preventing and correcting faulty closure of teeth.
- **General anesthesia** when medically necessary and administered for oral surgery.

IMPORTANT **A predetermination of benefits is recommended if the charge for any of the above items exceeds $200. See Predetermination of Benefits, page 25, for more information.**

When Expenses Are Incurred

The Claim Administrator pays claims that are **submitted within one year of the date of service**. The date of service is the incurred date and is determined using the following guidelines for each type of procedure:

- **Ordinary procedures**—incurred as of the date the service is rendered or the supply is furnished.
- **Fixed bridgework, crowns, inlays, onlays, or gold restorations**—incurred on the first date of preparation of the tooth or teeth.
- **Full or partial dentures**—incurred on the date the impression was taken.
- **Endodontics**—incurred on the date the tooth was opened for root canal therapy.

The date of incurred services can affect your benefits. See Example 3, page 18, for explanation.

Coordination of benefits from more than one group health plan may affect reimbursement rates. See the Coordination of Benefits chapter, page 29, for details.

Examples of Covered Expenses

Example 1

Type A and Type B Coverage with a Deductible

An Albuquerque employee's spouse went to the dentist for the first time since dependent coverage became effective. The dentist examined and x-rayed the patient's teeth, charted the present dental condition, and took a dental history. A dental hygienist, under the dentist's supervision, scaled and cleaned the patient's teeth. For these Type A services, the dentist charged $60.

As a result of the examination, the dentist crowned one tooth with porcelain and charged $675 for this Type B service (Code 2751).

Explanation: The DEP paid 100% of the charge for the Type A services—in this case, $60—determined to be within U&C. For the Type B service, the reimbursement schedule for Code 2751 allowed $371. (See Appendix A, Chart II, Schedule II, page A-8.) Because this was the dependent's first treatment under the DEP, the dependent had to satisfy the $25 annual deductible as described on page 6.

A summary of the reimbursement schedule appears in Appendix A, Chart II: DEP Reimbursement Schedule for Common Type B Procedures.

	Dentist's Charge	DEP Pays	Dependent Pays
Type A Services	$ 60	$ 60	$ 0
Type B Services (Code 2751)	675	346*	329
Total	$735	$406	$329

* $346 is derived by subtracting the $25 annual deductible from the $371 reimbursement amount.

The dependent has now satisfied the $25 annual deductible. All claims filed in the current calendar year for this dependent will be paid according to the reimbursement schedule as long as the employee remains continuously employed and insured by Sandia.

Example 2

Use of Predetermination of Benefits

After a dentist's initial examination and complete x-rays revealed serious dental disease, a Livermore employee was diagnosed by the dentist as needing three upper teeth extracted and replaced by a partial denture. Because of the potential cost involved, the employee asked the dentist to complete a predetermination of benefits. The exam and x-rays are Type A services, and the extractions and denture are Type B services. (See Appendix A, Chart II, Schedule IV, page A-9.)

Explanation: Assuming this patient had already satisfied the $25 annual deductible and this is a nonparticipating dentist, following is a summary of the reimbursement amounts:

	Dentist's Charge	DEP Pays	Employee Pays
Type A Services Exam and x-rays	$ 90	$60*	$ 30
Type B Services Extractions (Code 7140)	255	171	84
Denture (Code 5211)	950	528	422
Total	$1295	$759	$536

* For illustrative purposes, $60 was determined to be the usual and customary amount.

Because predetermination of benefits was used, the employee knows in advance that out-of-pocket expenses for these procedures will be $536.

Example 3

Effect of Date of Service on Benefits

For severe gum disease, an employee required extensive treatments that included extractions and a lower bridge. The services were performed during November, and reimbursements to the employee exhausted the $1500 calendar-year maximum. In December of the same year, the dentist determined that a full upper denture would be necessary. Extractions were performed and impressions were made in December. The denture was completed and delivered in January. The denture expense was incurred in December of the same year the employee had reached the annual $1500 maximum; therefore, these denture expenses are not eligible for reimbursement.

Example 4

Orthodontic Treatment

An Albuquerque employee's child was found to have a malocclusion, and required comprehensive orthodontic treatment. Orthodontic treatment is always a Type B expense.

Explanation: Assuming this patient has already satisfied the $25 annual deductible, and is enrolled in the DEP, following is a summary of the reimbursement amounts:

Date of Service	Service	Dentist's Charge	DEP Pays	Employee Pays
February 2004	First month of active treatment, which includes banding (Code 8080)	1000	617	383
March 2004 through February 2005	Active treatment after first month for 12 months (Dentist's charge is $125 per month)	1500	883*	617
March 2005 through July 2005	Active treatment per month (following reimbursement of maximum benefit)	625	0	625
Total		$3125	$1500	$1625

* The DEP pays $76 per month (in Albuquerque) toward the active treatment until the $1500 orthodontic lifetime maximum is reached.

Example 5

DeltaPreferred Option USA (DPO)

Here is an example of how you can save on dental costs by seeking treatment from a dentist who participates in the DeltaPreferred Option USA (DPO) network. (See Accessing Care, page 23.)

	DPO Dentist's Charge (Albuq.)	Non-Network Dentist's Charge
Fee for porcelain crown (Code 2750)	$657	$785
DEP pays	426	426
Patient pays	$231	$359

Note: The DPO fee shown above is the maximum allowable fee for procedure Code 2750 as of January 2004. DeltaPreferred Option USA maximum allowable fees are subject to change periodically at the discretion of Delta Dental, the Claim Administrator. The non-network dentist's charge is for illustrative purposes only.

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Exclusions

What the DEP Does Not Cover

As with all group health-care plans of this type, the DEP does not cover certain expenses. The following list itemizes most exclusions, but it is **not** all-inclusive.

- **Work done while NOT covered** under this DEP, except as provided under the Extension of Benefits Provision (see page 42).
- **Charges for services or supplies to the extent that they are:**
  - done for cosmetic purposes,
  - otherwise free of charge to patients,
  - not needed for proper dental care,
  - not included as a covered benefit as described in the DEP,
  - in excess of annual or lifetime maximum reimbursements,
  - rendered more than one year prior to the date of filing the claim,
  - in excess of U&C charges and the reimbursement schedules in Appendix A,
  - reimbursed through another primary plan's coordination of benefits (COB), or
  - claims that were eligible for COB but were not filed.
- **Care covered under other benefit plans, such as those of:**
  - the armed forces of any government,
  - any other benefit plan of Sandia,
  - any civil unit of any government, or
  - Workers' Compensation or similar laws.
- **Charges for:**
  - alteration of vertical dimension using appliances, restorations, or any procedures;
  - anesthesia, **except** general anesthesia when medically necessary in connection with oral surgery (see note below);
  - drugs or their administration (see note below);

Note: Prescription drugs and oral surgery may be covered under your Sandia medical plan.

- infection control;
- broken appointments;
- completion of claim forms or filing of claims;
- educational or training programs such as dietary instructions or plaque-control programs;
- extra sets of dentures, appliances, or prosthetic devices;
- illness or injury resulting from intentional acts of aggression, including armed aggression;
- replacement of teeth removed/lost **before** coverage is effective;
- replacing lost, stolen, or missing prosthetic appliances;
- toothbrushes (electric or manual); or
- treatment resulting from insurrection, participation in a riot, or service in the armed forces of any government.

■ **Treatments including (but not limited to):**

- experimental procedures;
- periodontal splinting;
- sealants (coverage of sealants under the DDP is described on page 57); or
- implantology (implants).

Note: Implants to reinforce an atrophied mandible may be covered under your Sandia medical plan.

IMPORTANT **Obtain a predetermination of benefits if there is any question about whether a specific service is covered. See Predetermination of Benefits, page 25, for more information.**

Accessing Care

Network (Participating) Providers

DeltaPreferred Option USA

The DeltaPreferred Option USA network is a network of national preferred providers with 40,000 dentists who contract with Delta Dental, the Claim Administrator. A DeltaPreferred Option USA dentist has agreed to accept Delta Dental's negotiated fee as their maximum fee.

You can obtain a copy of the maximum fee schedule for Albuquerque and Livermore for the DeltaPreferred Option USA dentists for the most common Type B procedures either through the web on the Benefits Home Page or by calling Sandia Line at 845-6789, dial 9, enter 1085#; if outside Albuquerque, dial 800-417-2634, then 845-6789.

Covered participants may choose a DeltaPreferred Option USA dentist from the participating provider list, which is published on www.deltadental.com along with a quick and easy search capability for looking up participating dentists by ZIP Code, by community or by name. Covered participants may also call Delta Dental Customer Service at 800-264-2818, Monday through Friday from 6:30 a.m. to 6:00 p.m. MST.

The advantages of the DeltaPreferred Option USA network are:

- Direct access to network dentists without preselection or referrals.
- Lower out-of-pocket expenses.
- Automatic claim filing by the participating dental office.

Note: In some instances, when you see a DeltaPreferred Option USA dentist, you may be asked to pay sales tax. This is an allowable charge under the DeltaPreferred Option USA contract and is the responsibility of the participant.

DeltaPreferred Option USA vs. DeltaPremier USA

Covered participants have the option to choose either a DeltaPreferred Option USA dentist or, for a higher out-of-pocket cost, a dentist who is not a preferred provider. While not all dentists participate in DeltaPreferred Option USA, three out of four

dentists nationwide participate in Delta Dental's fee-for-service network called DeltaPremier USA. If participants visit a DeltaPremier USA dentist they are assured that the dentist's charge will not exceed what Delta has certified as usual, customary and reasonable for that region.

In addition, covered participants may visit a nonparticipating dentist and still have coverage under the plan. Covered participants are responsible for payment at the time expenses are incurred.

IMPORTANT **DeltaPreferred Option USA dentists have agreed to a maximum allowable fee, established by Delta Dental, for any single procedure. The maximum allowable fee does not always match the DEP/DDP reimbursement amount. The difference between the DeltaPreferred Option USA dentist's maximum allowable fee and the DEP/DPP reimbursement is the responsibility of the covered participant. Likewise, the difference between a nonpreferred dentist's fee and the DEP/DDP reimbursement is the responsibility of the covered participant. The amount paid by the covered participants may be lower if a DeltaPreferred Option USA dentist is used.**

IMPORTANT **DeltaPreferred Option USA maximum allowable fees are subject to change periodically at the discretion of Delta Dental, the Claims Administrator.**

Recruitment of DeltaPreferred Option USA Dentists

Delta Dental offers DeltaPreferred Option USA membership to all practicing dentists in the community who are licensed to perform dental services. Those dentists who join DeltaPreferred Option USA agree to accept the lesser of the maximum allowable fee or their usual, customary and reasonable fee for coded dental procedures.

Sandia makes no endorsement regarding the comparative quality or professionalism of DeltaPreferred Option USA dentists versus nonpreferred dentists. Due diligence on the part of the participant is always necessary when selecting a dental health provider.

Removal of Dentists for DeltaPreferred Option USA

Dentists may be removed by Delta Dental from the DeltaPreferred Option USA network at their own request or after an investigation of their practices shows unprofessional or fraudulent behavior.

Problem/Complaint Resolution

If the covered participant has a problem with or complaint about a DeltaPreferred Option USA dentist, the participant should contact Delta Dental at 800-264-2818. Delta Dental will contact the dentist and work toward a resolution.

Nonnetwork (Nonparticipating) Providers

- A covered participant can access care from any licensed dentist.
- The covered participant will be responsible for payment at the time expenses are incurred and will have to file a claim form for reimbursement. (See Filing Your Claims, page 33.)

Predetermination of Benefits

If you or one of your dependents is likely to incur dental expenses of more than $200 (for example, dentures, crowns, root canals, braces), it is recommended, although not required, that you ask your dentist to file for predetermination of benefits. The Claim Administrator will then estimate and report the resulting coverage and reimbursement from the DEP as well as your out-of-pocket expenses.

Obtaining a predetermination of benefits provides you with a detailed description of the proposed treatment plan, including the American Dental Association standard procedure codes,* the dentist's estimated charges, and the DEP estimated reimbursement. With this information, you are able to analyze the need for a second opinion, learn of any DEP provisions that will disallow or affect your benefits, and estimate out-of-pocket costs.

Specifically, predetermination of benefits allows you and your dentist to determine in advance:

- Services that are covered,
- Reimbursements to be made under the DEP,
- Your out-of-pocket expenses, and
- Extent of planned dental work/procedures.

* With respect to orthodontic work, the predetermination of benefits will reflect the codes in Delta Dental's system and not the American Dental Association (ADA) codes.

The table below shows the procedure for filing for predetermination of benefits.

Step	Who	Action
1	Covered participant	Ask your dentist to file a predetermination of benefits for you. **Note:** All DeltaPreferred Option USA and DeltaPremier dentists will submit a predetermination of benefits for you using their standard claim form. If you visit a nonparticipating dentist and you need a claim form to use for a predetermination of benefits, you can obtain claim forms from the Sandia Benefits Customer Service Center, Sandia's internal web, or Sandia Line (845-6789, dial 9, enter 1284# for active employees or 1088# for retirees. If out of the Albuquerque area, dial 800-417-2634 first.).
2	Dentist	Inform the Claim Administrator of the proposed course of treatment by itemizing the service and charges on the claim form. Send copy to Claim Administrator and, if requested, to the patient.
3	Claim Administrator	■ Review the proposed treatment plan. ■ Determine what the DEP will reimburse (including deductible, if applicable) according to DEP guidelines, including Alternative Procedures, page 27. ■ Advise the covered participant that the estimated reimbursement may be changed if coverage is available under other health-care plans. See Coordination of Benefits (page 29). ■ Inform the covered participant and the dentist of the payment decision by issuing a summary of all procedures that will or will not be reimbursed, dentist charges, and potential DEP reimbursements.
4	Covered participant	Review the treatment plan and payment decision with your dentist before proceeding with the proposed plan.

IMPORTANT **If your dentist submits a treatment plan for predetermination of benefits and makes a change in the treatment plan, then the dentist should send in a revised plan so that the Claim Administrator can adjust the payments accordingly and advise you of any resulting changes in payment of claims.**

Alternative Procedures

An alternative procedure involves the substitution of a less costly but equally effective dental procedure in order to reduce the overall cost of treatment. There are usually several ways to treat a dental problem. For example, either a crown or a filling can perform equally well in certain situations. The same holds true in decisions about the use of precious metals versus plastic.

The Claim Administrator will base the payment of benefits on the alternative procedure and pay the scheduled amount for the alternative procedure as long as the result meets acceptable dental standards, and the procedures being reviewed and substituted are covered under the Sandia Dental Expense or Dental Deluxe Plans. The recommendation to use the alternative procedure will be made by a Delta Dental consultant.

IMPORTANT **If you and your dentist decide you want to use the more costly treatment, you are responsible for the charges beyond those for the less costly, appropriate treatment, which were reimbursed by the Claim Administrator.**

Delta Dental has the right to the final determination of an alternative procedure.

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Coordination of Benefits

Overview

When a covered participant has dental coverage under other group health plans, DEP payments are reduced so that total combined payments from all plans do **not** exceed 100% of the highest allowable DEP reimbursement. For preventive procedures, reimbursement from all plans shall not exceed 100% of the U&C charge. For restorative procedures, reimbursement from all plans shall not exceed 100% of reimbursement schedules in Appendix A.

Policy

All payments under the DEP are subject to coordination of benefits under other health-care plans.

When other health-care plans are involved, the primary plan is the plan that has the legal obligation to pay first. See Rules for Determining Which Plan is Primary and Other Details of the Benefit Payment, beginning on page 30.

Coordination of Benefits (COB):

- Applies only to group plans, not to insurance policies held by individuals; and
- Does **not** apply when married persons are both employed by Sandia.

When a plan (for example, an HMO) provides benefits in the form of service instead of cash payments, the reasonable cash value of each service is considered to be both:

- An allowable expense and
- A benefit paid.

Example

A covered Albuquerque employee's spouse requires a new upper denture (Code 5110, Appendix A, Chart II, page A-9). It has been five years since the original denture was purchased. Therefore, this expense is eligible for reimbursement. The spouse also has dental coverage under his own employer. The spouse files for predetermination of benefits under the DEP, and the dentist's charge will be $1100.

The Claim Administrator notifies the patient that the maximum allowable reimbursement will be $603 under the DEP, but this amount will be reduced by any other insurance plan's reimbursement. The claim will be paid as shown below.

A	B	C	D
Dentist's Charge	**Sandia's Scheduled Reimbursement Amount**	**Other Plan**	**Sandia Pays**
$1100	$603	$500	$103
Note: C + D is equal to or less than B.			

The patient's out-of-pocket expense is $497 ($1100 – $500 – $103 = $497).

Rules for Determining Which Plan is Primary and Other Details of the Benefit Payment

Use the following table to determine:

- Whether your plan is primary; and
- Which plan pays the benefit for employees, spouses, and dependents.

	If…	**then…**
1	the other plan (including HMOs) does not have a coordination of benefits (COB) provision,	the plan with no COB provision is primary.
2	both plans have COB provisions,	the plan covering the person as an employee is primary and will pay benefits up to the limits of that plan. The plan covering the person as a dependent is secondary and pays the remaining costs to the extent of coverage.
3	both plans have COB provisions and use the birthday rule for dependent children coverage,	the plan covering the parent whose birthday comes first (month and day) in the year is the primary plan and will pay benefits first. The plan covering the other parent is secondary and pays the remaining costs to the extent of coverage. **Sandia follows the birthday rule.**
4	both plans have COB but do not use the birthday rule,	the male-female rule applies. The rule says that the father's group insurance is the primary plan and will pay the benefits first. The mother's group insurance is secondary and pays the remaining costs to the extent of her coverage.

	If...	then...
5	both plans have COB but one parent is covered by the male-female rule and the other by the birthday rule,	the male-female rule applies. The rule says that the father's group insurance is the primary plan and will pay the benefits first. The mother's group insurance is secondary and pays the remaining costs to the extent of her coverage.
6	a divorce or legal decree establishes financial responsibility for health care for the dependent,	the parent who has that responsibility will be the holder of the primary plan.
7	a divorce decree does not establish financial responsibility for health care of the dependent,	the plan of the parent with custody is the primary plan. The other parent's plan is secondary.
8	a divorce decree does not establish financial responsibility and assigns joint custody,	each parent is primary when the child is living in that parent's home.
9	a divorce decree does not establish financial responsibility, and the parent with custody remarries,	the custodial parent's plan remains primary; the stepparent's plan is secondary. The noncustodial parent's plan is third.
10	payment responsibilities are still undetermined,	the plan that has covered the patient for the longest time is the primary plan.

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Filing Your Claims

Instructions

Instructions for filing a claim can be found on the Delta Dental claim form.

Note: If you use a DeltaPreferred Option USA, or DeltaPremier USA dentist, the dentist will file the claim on your behalf.

Where to Obtain Claim Forms

The Claim Administrator furnishes claim forms to Sandia. **Claim forms** can be obtained from the Sandia Benefits Customer Service Center, Sandia's internal web, or Sandia Line (845-6789, dial 9, enter 1284#, or 1088# for other DEP participants such as retirees. If out of the Albuquerque area, dial 800-417-2634 first.).

When to Submit Claims

It is recommended, whenever possible, that you submit all claims to the Claim Administrator within 90 days after the dental expenses are incurred.

It is generally a good idea to submit claims on an ongoing basis.

CAUTION—The DEP will not pay claims submitted more than one year after the date of service.

IMPORTANT **Your dentist should sign the claim form and/or the itemized bill. The Claim Administrator requires the dentist's original signature—no copies.**

If another insurance plan is the primary plan (see definition on page 30), file the claim with the DEP after filing with the primary plan. Complete the DEP claim form and attach the Explanation of Benefits from the primary plan as well as the itemized bill.

Mailing the Claim Form

Mail the claim form to the address of the Claim Administrator (also shown on the claim form) as follows:

Delta Dental
P. O. Box 9085
Farmington Hills, MI 48333-9085

Claims questions may be directed to the Delta Dental claims office at 800-264-2818.

Benefits under the DEP will be paid within approximately 14 working days after receipt of written proof of claim to:

- The provider, if the provider is a participating Delta Dental dentist, or
- You (the covered participant), if your provider is a nonparticipating dentist and you have not assigned the benefits. Assignment of benefits to a nonparticipating provider applies to the following states only:
  - Alaska
  - Alabama
  - Florida
  - Georgia
  - Idaho
  - Indiana
  - Louisiana
  - Mississippi
  - Montana
  - Nevada
  - Oregon
  - Texas
  - Utah
  - Washington

You should wait at least 30 days before inquiring about the status of your claim.

Right to Recover Excess Payments

Claim Administrator Rights

Benefits under the DEP are administered in accordance with the contract between Sandia and Delta Dental. Delta Dental has the right at any time to recover any amount paid by the DEP for covered charges in excess of the amount that should have been paid under the DEP provisions. Payments may be recovered from covered participants, providers of service, and other health-care plans.

IMPORTANT **By accepting benefits under the DEP, the covered participant agrees to cooperate in recovery of excess payments.**

Subrogation Rights

Subrogation rights refer to Sandia's right to recover any DEP payments made because of an injury to you or your dependent caused by a third party's wrongful act or negligence and which you or your dependent later recovered from the third party.

If you or your dependent is injured because of a third party's wrongful act or negligence, the DEP Claim Administrator will pay DEP benefits for that injury, subject to the conditions that you and your dependent:

- Agree in writing to Sandia being subrogated to any recovery or right against that third party,
- Will not take any action that would prejudice Sandia's subrogation rights, and
- Will cooperate in doing what is reasonably necessary to assist in any recovery.

Sandia will be subrogated only to the extent of DEP benefits paid because of that injury.

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Denied Claims and Appeals

Policy

You (the covered participant), your dependents, or another duly authorized person may appeal a claims denial or other action **if** you are seeking any of the following:

- Additional benefits,
- Full or partial claim payment for benefits that were denied, or
- Authorization for service that was initially not approved.

Written Notice of Claims Denial

If a claim for some or all of the benefits is denied, the Claim Administrator must provide the covered participant with:

- Written notice of the specific reasons,
- Reference to the pertinent DEP provisions,
- A description of any other material or information required from the covered participant or provider, and
- An explanation of why such material or information is being requested.

If a claim has been denied because of…	**then…**
eligibility,	contact the Sandia Benefits Customer Service Center. See Eligibility Appeal Procedures, page 12.
benefits administration or any other reason,	contact Delta Dental.

Procedure to Appeal Claims Denial

This is the procedure for appealing denial of claims:

Step	Who	Action
1	Covered participant or authorized representative	Submit to the Claim Administrator within 180 days after receipt of the denial: ■ A written request for reconsideration (appeal) and ■ Documents or records in support of the appeal. **Note:** The covered participant and his or her representative are entitled to review related documents in the Claim Administrator's possession.
2	Claim Administrator	Notify the covered participant of the decision on the appeal within 60 days of receipt of the appeal.

Time Limit for Filing an Appeal

You (the covered participant), your dependents, or another duly authorized person may appeal denial of claims or other actions in writing within 180 days after your receipt of notification of the Claim Administrator's decision. Send written request for review of any denied claim or other disputed matter directly to the Claim Administrator at:

Customer and Claims Services Department or Dental Director
Delta Dental
P. O. Box 30416
Lansing, MI 48909-7916

In any case, as a participant or dependent of a participant in this DEP, you may have further rights under the Employee Retirement Income Security Act (ERISA) of 1974. This information, as well as certain general information concerning the DEP, is included in the Sandia Employee Benefits binder as a separate booklet entitled ERISA Information.

Note: For retirees, the ERISA Information booklet is mailed separately or may be obtained by contacting the Sandia Benefits Customer Service Center.

IMPORTANT Delta Dental has the exclusive right to interpret and apply the provisions of the DEP, with the exception of eligibility, and the benefit claim decision is conclusive and binding. DEP provisions require that a covered participant pursue all claim and appeal rights described in this SPD before seeking any other legal recourse regarding claims for benefits.

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When Coverage Ends

This chapter explains when coverage ends for employees (active, retired, and on leave of absence) and dependents.

The Continuation and Conversion chapter, page 43, explains how coverage can be continued.

Note: Conversion to an individual policy is not available when the covered participant's DEP coverage stops.

Employees (Active and Retired)

Coverage under the DEP stops on the:

- Date the DEP is terminated,
- Date any cost of coverage is not paid when due, or
- Last day of the month the employee is no longer eligible (**except** as described in the Continuation and Conversion chapter, page 43).

Dependents (Spouses, Children, Domestic Partners and Domestic Partner Dependents)

Coverage under the DEP for dependents stops (**except** as described in the Continuation and Conversion chapter, page 43) on the:

- Last day of the month in which the employee dies or terminates,
- Last day of the month the dependent spouse legally divorces or legally separates from the employee/retiree,
- Last day of the month in which a domestic partner dependent no longer meets the criteria listed on page 8.
- Last day of the month a dependent child marries or ceases to be eligible, or
- Date a dependent child becomes eligible for coverage as an employee under the DEP.

Extension of Benefits Provision

Under the Extension of Benefits provision, the DEP will pay the scheduled amounts after coverage stops for the following services.

Service	Only if the dentist. . .
Prosthetic devices such as a full or partial denture	■ took the impressions and prepared the abutment teeth while the patient was covered by the DEP, and ■ delivers and installs the device within two calendar months after coverage stops.
Crowns	■ prepared the tooth for the crown while the patient was covered by the DEP, and ■ installs the crown within two calendar months after coverage stops.
Root canal therapy	■ opened the tooth while the patient was covered by the DEP, and ■ completed the treatment within two calendar months after coverage stops.

Continuation and Conversion

This chapter explains how benefits may be continued:

- During retirement and leave of absence;
- For the surviving spouse, dependents, and terminees; and
- For eligible persons under temporary continued coverage.

During Retirement

Sandia pays the full cost of coverage for you and your eligible dependents during retirement, if you retired:

- After January 1, 1988, with a service or disability pension from Sandia;
- Before January 1, 1988, with at least 15 years of service; or
- Between August 8, 1977, and January 1, 1988, at age 65 or older with at least 10 years of service as of age 65.

If you retire from Sandia, but do not meet any of the above conditions, you may continue coverage under the DEP by paying the full cost of premiums.

During a Leave of Absence (LOA)

LOA to the military—Coverage continues and the premium is paid by Sandia for the first six months of the leave. Employees remaining on an approved LOA beyond six months must pay the full premium in order to continue their dental benefits during the leave.

Child Care Leave of Absence—Coverage continues and the premium is paid by Sandia for the first six months of leave. Employees remaining on an approved LOA beyond six months must pay the full premium in order to continue their dental benefits during the leave.

Family Medical Leave Act (FMLA) Leave of Absence—Coverage continues and the premium is paid by Sandia for up to 12 weeks. Employees remaining on an approved LOA beyond 12 weeks must pay the full premium in order to continue their dental benefits during the leave.

Note: For military, child care, and FMLA leaves of absence, if you are enrolled in the Dental Deluxe Plan, you will be required to pay the applicable premium share for the first six months or 12 weeks, whichever is applicable.

All other LOAs—Coverage continues if the employee pays for it for the length of the LOA. Otherwise, coverage stops at the end of the month in which the LOA begins. You may be entitled to temporary continued coverage in some situations (see below).

Note: If you continue coverage under a leave of absence, this time counts toward temporary continued coverage under COBRA. See below.

Temporary Continued Coverage (COBRA) for Surviving Spouses, Dependents, and Terminees

The federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA), which became effective January 1, 1987, requires Sandia to offer a temporary extension of group health coverage to covered employees and dependents who lose their group health coverage as the result of certain events (listed on the next page). The cost of coverage is at the applicable group rates plus a 2% administrative fee.

Note: If you lost Plan coverage because of termination of employment and you are or become disabled, you will be charged 150% of the applicable group rate after the first 18 months. See Events Causing Loss of Coverage, page 45.

Qualified persons for this coverage include:

- The covered employee,
- The covered employee's spouse,
- The covered employee's eligible dependent children,
- The covered retiree's eligible dependent children, and
- The covered retiree's spouse

if covered under the DEP the day before the event causing loss of coverage (described on the following page).

In addition, a qualified beneficiary under COBRA also includes a child born to or placed for adoption with a covered employee or retiree during the period of the employee's or retiree's continuation coverage. Newborn children or adopted children need to be enrolled in the Plan within 31 calendar days from their date of birth, adoption, or placement for adoption, whichever is applicable. Once the newborn or adopted child is enrolled in continuation coverage pursuant to the Plan rules, the child will be treated like all other COBRA qualified beneficiaries.

If you have another group plan on the date of your qualifying COBRA event, you may still be eligible for COBRA. However, the other group health plan would provide your primary coverage; this Plan would provide only secondary coverage.

Covered persons terminated for cause by Sandia for gross misconduct are not eligible for any COBRA continuation.

Events Causing Loss of Coverage

The following table describes the events causing loss of coverage for terminees, surviving spouses, and dependents. The length of time of the optional COBRA coverage is noted.

If you are the . . .	and if the covered person loses DEP coverage because of . . .	then, under COBRA you have the right to choose temporary continued coverage for a maximum of . . .
employee, spouse, or a dependent child	■ a reduction in the number of hours of employment at Sandia, or ■ termination of employment, including retirement,	18 months.
employee, spouse, or a dependent child	termination of employment, and you are or become disabled within the first 60 days of your COBRA coverage as determined by Social Security and you do not have Medicare coverage,*	29 months (after the first 18 months you will be charged 150% of the cost of the regular premium).
employee's or retiree's spouse	■ the death of the Sandia spouse, or ■ a divorce or legal separation from your Sandia spouse,	36 months.
covered employee's dependent child or retiree's dependent child	■ the death of a Sandia parent, ■ a divorce or legal separation of your parents, or ■ a change in eligible status (i.e., dependent ceases to be a dependent child under the DEP),	36 months.

Note: Sandia's employees who work fewer than 25 hours as their normal work week may purchase coverage for their period of employment. If terminated, the 18-month temporary coverage above applies.

* You must notify the Sandia BCSC at 845-BENE (2363) 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.

Election Procedures

The following table shows the procedures to elect temporary continued coverage under COBRA so that Sandia provides coverage identical to DEP coverage **at your expense**.

Step	Who	Action
1	Employee or family member	Notify Sandia BCSC in writing at P. O. Box 5800, Albuquerque, NM 87185-1022 within 60 days* of ■ divorce, ■ legal separation, ■ loss of a child's dependent status, ■ disability designation by Social Security, or ■ death of a primary covered participant other than an employee.
2	BCSC	Notify the Sandia COBRA Administrator of covered participant's ■ death, ■ termination of employment, or ■ loss of eligibility.
3	Sandia COBRA Admin-istrator	Notify participants that they have the right to choose continued coverage within 60 days from the later of the following dates: ■ notification by Sandia BCSC, or ■ coverage actually ends.
4	Covered participant	Contact the COBRA Administrator at Sandia to elect COBRA coverage. ■ Covered participant has 60 days to elect COBRA from either the date of the notice or their loss of coverage date, whichever is later. ■ Covered participant has 45 days from the election date to make first premium payment and a 30-day grace period every month thereafter. ■ **If you elect continued coverage**, then Sandia provides coverage under the Plan **at your expense** plus the applicable administrative fee. ■ **If you do not elect continued coverage,** then group coverage under the Plan ends.

* If you fail to inform the Sandia BCSC within 60 days of the notification date, you will no longer be eligible to participate in COBRA.

Termination of Temporary Coverage

Temporary continued coverage under DEP may be terminated prior to 18, 29, or 36 months when:

- Sandia no longer provides coverage to any employee;
- The premium for continued coverage is not paid within the grace period; or
- The person becomes covered under any other type of group health plan, except if the other group plan has an exclusion or limitation regarding preexisting conditions.

Coverage extensions provided under the DEP or required under other laws (e.g., state law) continue concurrently with temporary continued coverage.

No Conversion Privileges

Conversion to an individual policy is **not** available when a covered participant's DEP coverage ends.

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Dental

Deluxe

Plan

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DDP Highlights

Summary of Plan Changes

This section contains a brief description of changes that have been implemented since the previous Dental Expense Plan and Dental Deluxe Plan SPD dated January 1, 2002.

- Eligibility has been changed to include qualifying same-gender domestic partner dependents (nonrepresented employees and OPEIU- and SPA-represented employees only).
- Dental procedure codes in Appendix A have been updated to reflect American Dental Association code revisions.
- For MTC- and OPEIU-represented employees and retirees, the eligibility requirement for unmarried children age 19 and over, but under age 24, changed from financially dependent and full-time student attending an institution of learning to financially dependent only.
- For MTC- and OPEIU-represented employees and former MTC- and OPEIU-represented retirees, the Dental Expense Plan (DEP) reimbursement schedule has been adjusted to reflect the current costs of the dental administrator, Delta Dental, for covered restorative services. The Dental Deluxe Plan (DDP) reimbursement schedule will reflect coverage at approximately 25% more than the DEP schedule.

Customer Service Contacts

Delta Dental is the Claim Administrator for Sandia's DEP and DDP. Dental plan questions may be directed to any of the following customer service telephone numbers:

Delta Dental	800-264-2818
Sandia Benefits Customer Service Center (Albuquerque)	505-845-2363 or 800-417-2634, then dial 845-2363
Sandia Benefits Department (Livermore)	925-294-2254

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Basic Provisions

The Dental Deluxe Plan (DDP) is an enhancement to the Dental Expense Plan (DEP) that provides a higher rate of reimbursement for claims. This plan is optional and requires a monthly premium payment. With the exception of any differences described in this chapter, **the plan description of the DEP provided in this booklet applies to the DDP as well**. Delta Dental is the current Claim Administrator for the DDP as well as the DEP. Coverage under the DDP was first offered during Sandia's Benefits Choices 1996 Open Enrollment period (October 20–November 9, 1995).

IMPORTANT **Once enrolled, a two-year mandatory participation is required. Enrollment will be offered every other year during the Open Enrollment period. For example, this means coverage will be effective January 1, 2004, through December 31, 2005. The next time the DDP will be offered will be during Open Enrollment 2005 for coverage effective January 1, 2006, through December 31, 2007.**

Payment of Premiums

- You have a choice of DDP deductions being taken on a pretax or an after-tax basis. The deductions will begin at the beginning of the calendar year following the applicable Open Enrollment period.
- The premium will remain the same during the two-year mandatory participation period as indicated in the applicable Open Enrollment materials.

ERISA Information

As a participant in the 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 in your Employee Benefits binder and is entitled ERISA Information.

Note: For retirees, the ERISA information is mailed separately or may be obtained by contacting the Sandia Benefits Customer Service Center.

Plan Information

The Dental Deluxe Plan (DDP) is a self-insured plan, which is also partially subsidized by employee-paid premiums for eligible participants (as defined in this booklet) of Sandia National Laboratories, P. O. Box 5800, Albuquerque, NM, 87185 (Employer Identification Number 85-0097942).

Delta Dental, the Claim Administrator, has assigned the following group plan number: **9550**. For information concerning service of legal process, contact the Sandia Legal Division, Sandia National Laboratories, P. O. Box 5800, MS 0141, Albuquerque, NM, 87185.

The 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.

Eligibility

- New employees and their dependents are not eligible to participate until the next DDP enrollment period.

Note: For this Plan, employees hired between the time of Open Enrollment in which the DDP is offered and the beginning of the winter shutdown in December (of the same calendar year) have 31 calendar days to enroll. Enrollment will be effective January 1 of the next calendar year.

- In order to enroll, eligible employees must be on roll as of December 31 of the year the DDP is offered (see Eligibility chapter on page 7).
- Married couples both employed by Sandia
  - One spouse may cover the other spouse, or they may each have their own coverage.
  - If you desire coverage for your dependent children, they must be covered under one spouse. Dependent children cannot be divided between spouses.
  - Employees cannot cover their dependent children unless the employee is covered. All dependent children must be listed under the same plan—either the DEP or the DDP.
- Employees enrolled in the DDP who then retire must continue coverage through a pension deduction for the remainder of the two-year mandatory enrollment period.
- Employees enrolled in the DDP who then terminate (for reasons besides retirement) can continue coverage in either the DDP or the DEP through COBRA.
- Adding or deleting dependents will require notification within 31 calendar days of a mid-year election change event (i.e., birth, death, dependent status change, marriage). If you fail to enroll your dependent within 31 calendar days of his or her eligibility, you must wait until the next DDP Open Enrollment period to enroll the dependent for coverage effective the calendar year following the DDP enrollment period.
- Current retirees are **not** eligible for the DDP.
- Class II dependents are **not** eligible for dental coverage.

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DDP Coverage Enhancements

- Sealants are covered at 100% of U&C fees for enrolled dependent children under age 14 only. Coverage will be limited to one sealant per lifetime per permanent molar.
- The DDP reimbursement schedule reflects coverage at approximately 25% more than the DEP reimbursement schedule. (See Appendix A, Chart III, for the current DDP schedule.)
- The annual maximum benefit for nonorthodontic covered expenses is $1800.
- The **lifetime** maximum benefit for orthodontic covered expenses is $1800.

  Note: If you elect the DDP, in order to receive the $1800 lifetime maximum for orthodontic covered expenses, orthodontic services must START after January 1 of the year following the applicable Open Enrollment period. (Your orthodontic lifetime maximum under the DEP is $1500.)

  Note: If you elect the DDP, orthodontic services must occur within the two-year enrollment period for you to receive the DDP reimbursement and maximum. Unless you enroll in the DDP for an additional two years, DEP reimbursements and maximum will apply.

- The COB provision is higher than it is under the DEP. The following is an example of how COB works under the DDP only.

A	B	C	D
Dentist's Charge	**Sandia's Scheduled Reimbursement Amount**	**Other Plan**	**Sandia Pays**
$600	$469	$350	$250
600	469	600	0
600	469	100	469
Note: C + D is equal to or less than A.			

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Appendix A

Reimbursement Schedules

This appendix provides the scheduled allowed reimbursement amounts for common Type B services for the DEP and the DDP.

Chart I assigns the appropriate reimbursement schedule number to the location of your dentist for the **DEP** and the **DDP**.

Chart II lists the dollar amount of the **DEP** reimbursements based on the schedule number.

Chart III lists the dollar amount of the **DDP** reimbursements based on the schedule number.

The following instructions may be used to determine scheduled reimbursements.

<table>
<tr><th>Step</th><th>Procedure</th></tr>
<tr><td>1</td><td>Refer to Chart I, Geographic Location of Dentist, and determine the schedule number (I, II, III, or IV) applicable to your dentist's location.
Example:
<table>
<tr><td>If your dentist practices in</td><td>Then on Chart II (DEP) use</td></tr>
<tr><td>New Mexico</td><td>Schedule II</td></tr>
<tr><td>Amarillo, TX</td><td>Schedule II</td></tr>
<tr><td>Washington, DC</td><td>Schedule III</td></tr>
<tr><td>Livermore, CA</td><td>Schedule IV</td></tr>
<tr><td>Las Vegas, NV</td><td>Schedule IV</td></tr>
</table></td></tr>
<tr><td>2</td><td>Obtain from your dentist the procedure code of the service to be performed.</td></tr>
<tr><td>3</td><td>Refer to Chart II or Chart III, later in this appendix, Reimbursement Schedule for Common Type B Dental Procedures for the DEP or the DDP, and find the procedure code and description of the service to be performed.
Note: Only the most common dental procedure codes are described in this appendix. If you do not find a particular procedure code, we recommend that you ask your dentist to call Delta Dental for the reimbursement amount or to file a predetermination on your behalf. Due to the many variables that impact the benefit payment (such as coordination of benefits, plan limitations, deductibles, maximums and plan selection), Delta Dental is not able to quote a reimbursement amount to a Sandia participant over the telephone. Delta Dental will quote Sandia's reimbursement fees over the telephone to dentists only and only for unique procedure codes under the American Dental Association's CDT-3 nomenclature.
Scan across to the appropriate Reimbursement Schedule number (I–IV determined in Step 1 above) to find the dollar amount to be reimbursed.</td></tr>
</table>

Chart I
Geographic Location of Dentist

Dentist's Location	Schedule No.
Alabama	
City of Montgomery (ZIP Codes beginning with 361 only)	II
Remainder of State	I
Alaska	II
Arizona	II
Arkansas	
City of Little Rock (ZIP Codes beginning with 722 only)	II
Remainder of State	I
California	
Livermore and Greater San Francisco Area (ZIP Codes beginning with 940–951 only)	IV
Greater Los Angeles Area (ZIP Codes beginning with 900–918 and 926–931)	IV
Remainder of State	III
Colorado	
Greater Denver Area (ZIP Codes beginning with 800–803 only)	III
Remainder of State	II
Connecticut	
New London Area (ZIP Codes beginning with 063 only)	II
Waterbury Area (ZIP Codes beginning with 067 only)	II
Remainder of State	III
Delaware	
City of Wilmington (ZIP Codes beginning with 198 only)	III
Remainder of State	II
District of Columbia	III
Florida	
Pensacola Area (ZIP Codes beginning with 324–325 only)	II
Orlando Area (ZIP Codes beginning with 327–329 only)	II
Tampa/St. Petersburg Area (ZIP Codes beginning with 335–337 only)	II
Remainder of State	III

Dentist's Location	Schedule No.
Georgia	
City of Atlanta (ZIP Codes beginning with 303 only)	III
Atlanta Area (ZIP Codes beginning with 300–302 only)	II
Greater Savannah Area (ZIP Codes beginning with 313–314 only)	II
Remainder of State	I
Hawaii	III
Idaho	II
Illinois	
Chicago and Area (ZIP Codes beginning with 600–607 only)	III
Remainder of State	II
Indiana	
Indianapolis Area (ZIP Codes beginning with 460–462 only)	II
Gary, South Bend, Ft. Wayne, and surrounding areas (ZIP Codes beginning with 463–469 and 473 only)	II
Remainder of State	I
Iowa	I
Kansas	II
Kentucky	I
Louisiana	
City of Baton Rouge (ZIP Codes beginning with 708 only)	III
Remainder of State	II
Maine	I
Maryland	III
Massachusetts	II
Michigan	
Detroit Area (ZIP Codes beginning with 480–483 only)	IV
Flint (ZIP Codes beginning with 485 only)	III
Lansing (ZIP Codes beginning with 489 only)	III
Grand Rapids (ZIP Codes beginning with 495 only)	III
Remainder of State	II

Dentist's Location	Schedule No.
Minnesota	
Minneapolis-St. Paul (ZIP Codes beginning with 551 and 554 only)	II
Remainder of State	I
Mississippi	
City of Jackson (ZIP Codes beginning with 392 only)	II
Remainder of State	I
Missouri	
Greater St. Louis Area (ZIP Codes beginning with 630–633 only)	II
Greater Kansas City Area (ZIP Codes beginning with 640–641 only)	II
Remainder of State	I
Montana	II
Nebraska	
City of Omaha (ZIP Codes beginning with 681 only)	II
Remainder of State	I
Nevada	IV
New Hampshire	II
New Jersey	
Southern New Jersey (ZIP Codes beginning with 080–084 only)	II
Remainder of State	III
New Mexico	II
New York	
Westchester and Putnam Counties (ZIP Codes beginning with 105–108 only)	III
Monticello, Glens Falls, and Plattsburgh Areas (ZIP Codes beginning with 127, 128, and 129 only)	I
Ogdensburg, Binghamton, Jamestown/Olean, Corning/Elmira Areas (ZIP Codes beginning with 136, 137–139, 147, and 148–149 only)	I
Remainder of State	II
North Carolina	II
North Dakota	I

Dentist's Location	Schedule No.
Ohio	
Greater Cleveland Area (ZIP Codes beginning with 440–441 only)	III
Greater Cincinnati Area (ZIP Codes beginning with 450–452 only)	I
Remainder of State	II
Oklahoma	
Oklahoma City Area (ZIP Codes beginning with 730–731 only)	II
Tulsa Area (ZIP Codes beginning with 740 and 741 only)	II
Remainder of State	I
Oregon	II
Pennsylvania	
City of Pittsburgh (ZIP Codes beginning with 152 only)	III
Remainder of State	II
Rhode Island	II
South Carolina	
Charleston Area (ZIP Codes beginning with 294 only)	II
Remainder of State	I
South Dakota	I
Tennessee	
City of Nashville (ZIP Codes beginning with 372 only)	II
City of Memphis (ZIP Codes beginning with 381 only)	II
Remainder of State	I
Texas	
Amarillo (ZIP Codes beginning with 791 only)	II
City of Houston (ZIP Codes beginning with 770–772 only)	IV
Houston Area, including Beaumont (ZIP Codes beginning with 773–777 only)	III
Dallas, Fort Worth, and Waco Areas (ZIP Codes beginning with 750–752 and 760–761 and 766–767 only)	III
Corpus Christi Area (ZIP Codes beginning with 783–785 only)	III

Dentist's Location	Schedule No.
City of Austin (ZIP Codes beginning with 787 only)	III
Lubbock Area (ZIP Codes beginning with 793–794 only)	III
Remainder of State	II
Utah	I
Vermont	I
Virginia	
Washington, DC Area (ZIP Codes beginning with 220–223 only)	III
Remainder of State	II
Washington	
Seattle, Tacoma and Area (ZIP Codes beginning with 980–984 only)	III
Remainder of State	II
West Virginia	
Charleston Area (ZIP Codes beginning with 250–253 only)	II
Wheeling Area (ZIP Codes beginning with 260 only)	II
Remainder of State	I
Wisconsin	II
Wyoming	II
Outside the USA (Including 006–009 and 969, which is Puerto Rico, Virgin Islands, and Guam)	II

Chart II
DEP Reimbursement Schedule for Common Type B Procedures

Use Chart II, pages A-8 through A-10, to find the dollar amount of the reimbursement for the applicable schedule number (I, II, III, or IV) determined from Chart I.

Note: The reimbursement schedule for the optional Dental Deluxe Plan is given in Chart III. The instructions are the same, but the rates are different, so if you have opted for the Dental Deluxe Plan, use Chart III.

Within Chart II, frequently used schedule numbers in common Sandia employee locations are as follows:

If your dentist practices in	Then on Chart II (DEP) use
New Mexico	Schedule II
Livermore, CA	Schedule IV

Chart II: Dental Expense Plan Reimbursement Schedule for Common Type B Procedures

Code	Service	Reimbursement Amount per Schedule ($)			
		I	II	III	IV
	Amalgams				
2140	1 surface, primary or permanent	41	51	55	58
2150	2 surfaces, primary or permanent	53	66	71	75
2160	3 surfaces, primary or permanent	64	80	86	90
2161	4+ surfaces, primary or permanent	78	98	106	111
	Composite Resins				
2330	1 surface, anterior	45	56	60	63
2331	2 surfaces, anterior	58	72	78	82
2332	3 surfaces, anterior	73	91	98	103
	Crowns				
2740	Porcelain/ceramic	359	449	485	509
2750	Porcelain fused to high noble metal	341	426	460	483
2751	Porcelain fused to base metal	297	371	401	421
2752	Porcelain fused to noble metal	309	386	417	438
2780	Crown–¾ cast high noble	343	429	463	487
2781	Crown–¾ cast base metal	343	429	463	487
2782	Crown–¾ cast noble metal	345	431	466	489
2783	Crown–¾ porcelain ceramic	327	409	442	464
2790	Full cast high noble metal	330	413	446	468
2930	Stainless steel, primary tooth	77	96	104	109
	Root-canal therapy				
3310	Anterior	208	260	281	295
3320	Bicuspid	232	290	313	329
3330	Molar	299	374	404	424
	Periodontics				
4210	Gingivectomy—per quadrant	218	272	294	309

Code	Service	Reimbursement Amount per Schedule ($)			
		I	II	III	IV
4260	Osseous surgery—including flap entry and closure, per quadrant	362	453	489	513
4263	Bone replacement graft—first tooth in quadrant	185	231	249	261
4341	Periodontal scaling and root planing, per quad-rant	78	98	106	111
	Prosthodontics				
	Complete denture, including routine postdelivery care:				
5110	Complete upper	482	603	651	683
5120	Complete lower	483	603	652	684
5130	Immediate upper	525	657	710	745
5140	Immediate lower	504	630	680	714
	Partial denture, including 6 months postdelivery care:				
5211	Upper partial with conventional clasps, rests, and teeth, resin base	373	466	503	528
5212	Lower partial with conventional clasps, rests, and teeth, resin base	375	469	507	532
	Bridge pontics:				
6210	Cast high noble metal	324	405	437	459
6242	Porcelain fused to noble metal	306	383	414	435
6252	Resin with noble metal	229	286	309	324
	Oral Surgery				
7140	Extraction of tooth, erupted (elevation and/or forceps removal)	40	50	54	57
7210	Extraction of tooth, erupted	72	90	97	102
7230	Extraction of tooth, partial bony impaction	110	138	149	156
7240	Extraction of tooth, complete bony impaction	126	157	170	179

Code	Service	Reimbursement Amount per Schedule ($)			
		I	II	III	IV
	Orthodontics				
0150	Orthodontic Exam	100% of U&C			
0330	Panoramic Film	100% of U&C			
0340*	Cephalometric Film	100% of U&C			
0470*	Diagnostic Casts	100% of U&C			
8010/8020/8030	Limited Orthodontic Treatment				
	Initial Fee	159	199	214	226
	Monthly Fee	31	39	42	44
8040	Limited Orthodontic Treatment—Adult Dentition				
	Initial Fee	494	617	665	699
	Monthly Fee	61	76	82	86
8050/8060	Interceptive Orthodontic Treatment				
	Initial Fee	159	199	214	226
	Monthly Fee	31	39	42	44
8070/8080/8090	Comprehensive Orthodontic Treatment				
	Initial Fee	494	617	665	699
	Monthly Fee	61	76	82	86
8210	Removable Appliance Therapy	159	199	214	226
8220	Fixed Appliance Therapy	159	199	214	226
8680	Orthodontic Retention/Retention Appliance	106	133	143	151

Note: These are the procedure codes used by the American Dental Association (ADA) for orthodontic services, which dentists use to bill services. Procedure codes are different in Delta Dental's system. The Explanation of Benefits you receive will reflect the codes in Delta Dental's system and not the ADA codes.

* If billed by an orthodontist, this reimbursement will apply toward your orthodontic maximum benefit.

Chart III
DDP Reimbursement Schedule for Common Type B Procedures

If you have opted for the Dental Deluxe Plan, use Chart III, pages A-12 through A-14, to determine the dollar amount of the reimbursement for the applicable schedule number (I, II, III, IV) determined from Chart I. If your dentist practices in New Mexico, your schedule number is II. If your dentist practices in Livermore, California, your schedule number is IV. If your dentist practices in another location, use Chart I in Appendix A to determine your schedule number.

Chart III: Dental Deluxe Plan Reimbursement Schedule for Common Type B Procedures

Code	Service	Reimbursement Amount per Schedule ($)			
		I	II	III	IV
	Amalgams				
2140	1 surface, primary or permanent	51	64	69	73
2150	2 surfaces, primary or permanent	66	83	89	94
2160	3 surfaces, primary or permanent	80	100	108	113
2161	4+ surfaces, primary or permanent	98	123	133	139
	Composite Resins				
2330	1 surface, anterior	55	69	75	79
2331	2 surfaces, anterior	71	89	96	101
2332	3 surfaces, anterior	90	113	122	128
	Crowns				
2740	Porcelain/ceramic	450	562	607	637
2750	Porcelain fused to high noble metal	426	533	576	605
2751	Porcelain fused to base metal	371	464	501	526
2752	Porcelain fused to noble metal	386	483	522	548
2780	Crown–¾ cast high noble	429	536	579	609
2781	Crown–¾ cast base metal	429	536	579	609
2782	Crown–¾ cast noble metal	431	539	583	611
2783	Crown–¾ porcelain ceramic	409	511	553	580
2790	Full cast high noble metal	413	516	557	585
2930	Stainless steel, primary tooth	96	120	130	137
	Root-canal therapy				
3310	Anterior	260	325	351	369
3320	Bicuspid	290	362	391	411
3330	Molar	374	468	505	530
	Periodontics				
4210	Gingivectomy—per quadrant	273	340	368	386

Code	Service	Reimbursement Amount per Schedule ($)			
		I	II	III	IV
4260	Osseous surgery—including flap entry and closure, per quadrant	453	566	611	642
4263	Bone replacement—first tooth in quadrant	231	289	312	328
4341	Periodontal scaling and root planing, per quadrant	98	123	133	140
	Prosthodontics				
	Complete denture, including routine postdelivery care:				
5110	Complete upper	603	754	814	854
5120	Complete lower	604	754	815	855
5130	Immediate upper	656	821	888	931
5140	Immediate lower	630	787	850	893
	Partial denture, including 6 months postdelivery care:				
5211	Upper partial with conventional clasps, rests, and teeth, resin base	466	582	629	660
5212	Lower partial with conventional clasps, rests, and teeth, resin base	469	586	633	665
	Bridge pontics:				
6210	Cast high noble metal	405	506	546	573
6242	Porcelain fused to noble metal	383	479	517	543
6252	Resin with noble metal	286	358	387	406
	Oral Surgery				
7140	Extraction of tooth, erupted (elevation and/or forceps removal)	50	62	67	70
7210	Extraction of tooth, erupted	90	113	121	128
7230	Extraction of tooth, partial bony impaction	138	172	186	195
7240	Extraction of tooth, complete bony impaction	157	196	212	223

Code	Service	Reimbursement Amount per Schedule ($)			
		I	II	III	IV
	Orthodontics				
0150	Orthodontic Exam	100% of U&C			
0330	Panoramic Film	100% of U&C			
0340*	Cephalometric Film	100% of U&C			
0470*	Diagnostic Casts	100% of U&C			
8010/8020/8030	Limited Orthodontic Treatment				
	Initial Fee	199	249	268	283
	Monthly Fee	39	49	53	55
8040	Limited Orthodontic Treatment—Adult Detention				
	Initial Fee	618	771	831	874
	Monthly Fee	76	95	103	108
8050/8060	Interceptive Orthodontic Treatment				
	Initial Fee	199	249	268	283
	Monthly Fee	39	49	53	55
8070/8080/8090	Comprehensive Orthodontic Treatment				
	Initial Fee	618	771	831	874
	Monthly Fee	76	95	103	108
8210	Removable Appliance Therapy	199	249	268	283
8220	Fixed Appliance Therapy	199	249	268	283
8680	Orthodontic Retention/Retention Appliance	133	166	179	189

Note: These are the procedure codes used by the American Dental Association (ADA) for orthodontic services, which dentists use to bill services. Procedure codes are different in Delta Dental's system. The Explanation of Benefits you receive will reflect the codes in Delta Dental's system and not the ADA codes.

* If billed by an orthodontist, this reimbursement will apply toward your orthodontic maximum benefit.

Appendix B

Acronyms

ADA	American Dental Association
BCSC	Benefits Customer Service Center
COB	coordination of benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
DDP	Dental Deluxe Plan
DEP	Dental Expense Plan
DPO	DeltaPreferred Option USA
EBC	Employee Benefits Committee
ERISA	Employee Retirement Income and Security Act (of 1974)
FMLA	Family Medical Leave Act
HIPAA	Health Insurance Portability and Accountability Act
HMO	health maintenance organization
LOA	Leave of Absence
SPD	Summary Plan Description
U&C	usual and customary
QMCSO	Qualified Medical Child Support Order

Definitions

abutment — a tooth or root used as an anchor for either a fixed or a removable dental prosthesis.

anesthesia — **local**—the administration of specific agents to achieve the loss of conscious pain response in a specific location or area of the body.
general—the administration of specific agents to render the patient completely unconscious.

anesthetic — a drug that produces loss of feeling or sensation either generally or locally.

appliance a device used to provide function or a healing effect.

fixed—a device cemented to the teeth or attached by adhesive materials.
prosthetic—used to replace a missing tooth.

bitewing dental x-ray showing approximately the crown half of the upper and lower jaws.

bridgework **fixed**—a prosthesis or a partial denture replacing one or several teeth and retained with crowns or inlays cemented to the natural teeth, which are used as abutments.
fixed-removable—a partial denture that the dentist can remove but the patient cannot.
removable—a partial denture retained by attachments that permit removal of the denture. Normally held by clasps.

child Under this Plan, a **"child"** is defined as:

- The primary participant's or domestic partner's own child;
- An adopted child of the primary participant or domestic partner, if the preadoption agreement and/or final adoption papers have been completed and submitted to the Sandia Benefits Customer Service Center;
- A stepchild who lives with the covered participant at least 50% of the year (stepchildren visiting for the summer are not considered to be living with you) or living in a home provided by you;
- A child of the covered participant, if a court decree requires the covered participant to provide coverage; or
- A child living with the covered participant for whom the covered participant (or covered participant's spouse or eligible domestic partner) is the legal guardian.

Claim Administrator the third party designated by Sandia to receive, process, and pay claims according to the provisions of the DEP and DDP.

copayment cost-sharing feature in which the DEP or DDP pays a portion of the covered charge, and the covered person pays the balance of that covered charge.

covered charge — a dental expense incurred by the covered person and payable under the terms of the DEP or DDP.

covered participant — an eligible employee, retiree, employee on leave of absence, other eligible persons (described in the Eligibility chapters on page 7 and page 55), or their dependents who are eligible for coverage under the DEP or the DDP.

course of treatment — a planned program of one or more covered expenses, whether rendered by one or more dentists, for treating a dental condition diagnosed by the attending dentist as a result of an oral exam. The course of treatment begins on the date a dentist first renders a service to correct or treat the diagnosed dental condition.

crown — the part of a tooth that is covered by enamel.

dental hygienist — a person trained to

- remove calcareous deposits and stains from the surfaces of the teeth.
- provide additional services and information on how to prevent oral disease.

dentist — a person licensed to practice dentistry. In this booklet, the term "dentist" also includes a doctor licensed to perform the particular dental service rendered.

denture — a device replacing missing teeth.

endodontic therapy — See "root canal therapy."

experimental procedure — a procedure or treatment method that has not been approved by the Food and Drug Administration.

fluoride — a solution of fluorine applied to the teeth to prevent dental decay.

implant — prostheses made of metal or other foreign material that is placed onto or on the bone to provide support.

impression — a negative reproduction of a given area. **Example:** in bridgework, an impression of a tooth that has been prepared for an inlay or crown.

incur	the date a service is actually performed, or the date a supply or material is actually ordered, even though the service or material may be part of a course of treatment.
infection control	gloves, gowns, masks, and sterilizing of instruments and chair.
inlay	a restoration made to fit a prepared tooth cavity and then cemented into place.
malocclusion	an abnormal relation of the opposing teeth when brought into habitual opposition.
medically necessary	services or supplies provided by a dentist, physician, hospital, or other provider that the Claim Administrator has determined are appropriate for the covered person's diagnosis and treatment in accordance with generally accepted local and national standards of dental or medical practice and not primarily for the convenience of the covered person or provider. The services/supplies are the most appropriate that can safely be provided.
onlay	an occlusal rest or restoration that is extended to cover the entire surface of the tooth. It is often used to restore lost tooth structure and to increase tooth height.
orthodontics	the branch of dentistry primarily concerned with detecting, preventing, and correcting abnormalities in how the teeth are positioned in relation to the jaws. Commonly known as "straightening" the teeth.
partial denture	a prosthesis that replaces one or more, but less than all, of the natural teeth and associated structures and that is supported by the teeth or the gums, or both. A "partial" may be removable, fixed removable, or fixed; one side or two sides.
periapical	enclosing or surrounding the tissues and bony sockets of the teeth.
periodontal splinting	stabilization of loose teeth; commonly involves wiring to tie several teeth together.
pontic	the part of a fixed bridge that is suspended between the abutments and that replaces a missing tooth or teeth.

prophylaxis	the removal of tartar and stains from the teeth; the cleaning of the teeth by a dentist or dental hygienist.
prosthesis	an artificial replacement of one or more natural teeth and/or associated structures.
restoration	a broad term applied to any inlay, crown, bridge, partial denture, or complete denture that restores or replaces loss of tooth structure, teeth, or oral tissue. The term applies to the end result of repairing and restoring or reforming the shape, form, and function of part or all of a tooth or teeth.
retired employee	a former employee who has retired on a service or disability pension.
root canal therapy	(also called endodontic therapy) treatment of a tooth having a damaged pulp. Usually done by completely removing the pulp, sterilizing the pulp chamber and root canals, and filling these spaces with sealing material.
sealant	an adhesive that bonds the surface of a tooth and offers protection against outside chemical or physical agents.
scale	to remove tartar and stains from the teeth with special instruments.
topical	painting the surface of the teeth as in fluoride treatment, or applying a cream-like anesthetic formula to the surface of the gum.
usual and customary (U&C) charges	the amount determined by the Claim Administrator based on the range of fees charged by dentists with comparable training and experience for the same or similar service within the locality. This determination considers your unique situation such as special skills required by your dentist, additional time required, or unusual circumstances. The DEP allows for payment up to, but not over, the U&C charges for preventive and diagnostic (Type A) services (only), as described in the Coverage chapter.

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Appendix C

Health Insurance Portability and Accountability Act (HIPAA) of 1996

Effective April 14, 2003, a federal law known as the Health Insurance and Portability and Accountability Act of 1996 (HIPAA), required 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 (see below for further information).

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 will require all of its business associates to also 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 or employee 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, receive an accounting of certain disclosures of the information and, under certain circumstances, 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 were distributed to all current enrollees in the Plan by April 2003, and are distributed to new primary participants upon enrollment in the Plan. In addition, a copy of this notice is available upon request by contacting the Benefits Customer Service Center. If you have questions about the privacy of your health information or you wish to file a complaint under HIPAA, please contact the HIPAA Privacy Officer for the Benefits Department.

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