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

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

May 2008

Dear UHC Standard PPO Plan Participant:

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

Effective January 1, 2007:

Entire SPD
The Following Should be Noted:
Replace all references of Care Coordination℠ to Personal Health Support Replace all references of a UHC Nurse to a Personal Health Support Nurse Remove all references to after-tax premium deductions

Section 3: Enrollment and Disenrollment		
Pages:	Under Heading:	The Following Should be Noted:
3-3; 3-4	Enrolling Class I Dependents	**Delete:** You must provide a copy of the marriage license or birth certificate within 60 calendar days of the birth or marriage, otherwise your dependent will be disenrolled. **Replace with:** You must provide a copy of the marriage or birth certificate within 60 calendar days of the birth or marriage. Your dependent will not be enrolled until this paperwork is received.

Section 6: Coverages/Limitations		
Pages:	Under Heading:	The Following Should be Noted:
6-24	Immunizations/ Flu Shot Services	**Delete:** If you are unable to obtain the type of immunization required at the physician's office (e.g. malaria pills) in Albuquerque, New Mexico, you can go to Concentra, 3800 Commons NE (505-822-9480) and receive in-network benefits. If you need different types of immunizations for personal travel where at least one of these is not available at a physician's office, you may obtain all of your immunizations at Concentra. If you are located anywhere else in the United States, contact UHC customer service at 1-877-835-9855. **Replace with:** If you are unable to obtain the type of immunization required for personal travel at the physician's office (e.g. malaria pills), contact UHC Customer Service at 1-877-835-9855 to request a network gap exception.

Appendix C: UHC Premier Acronyms and Definitions		
Pages:	Under Heading:	The Following Should be Noted:
C-6	Eligible Expenses	**Delete:** Eligible expenses are charges for covered health services that are provided while the plan is in effect, determined as follows: – in-network benefits – contracted rates with the provider – out-of-network benefits: o Selected data resources which, in the judgment of the Claims Administrator, represent competitive fees in that geographic area or o Negotiated rates agreed to by the out-of-network provider and either the Claims Administrator or one of its vendors, affiliates, or subcontractors These provisions do not apply if you receive covered health services from an out-of-network provider in an emergency. In that case, eligible expenses are the amounts billed by the provider, unless the Claims Administrator negotiates lower rates. Eligible expenses are subject to the Claims Administrator's reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from the Claims Administrator. **Replace with:** Charges for covered health services that are provided while the plan is in effect, determined as follows: – In-network benefits – contracted rates with the provider – Out-of-network benefits: o Negotiated rates agreed to by the out-of-network provider and either the Claims Administrator or one of its vendors, affiliates, or subcontractors o The following: ▪ Selected data resources which, in the judgment of the Claims Administrator, represent competitive fees in that geographic area; ▪ Fees that are negotiated with the provider; ▪ 70% of the billed charge; or ▪ A fee schedule that the Claims Administrator develops. These provisions do not apply if you receive covered health services from an out-of-network provider in an emergency. In that case, eligible expenses are the amounts billed by the provider, unless the Claims Administrator negotiates lower rates. Eligible expenses are subject to the Claims Administrator's reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from the Claims Administrator.

Effective October 1, 2007:

Section 10: Claims and Appeals		
Pages:	Under Heading:	The Following Should be Noted:
10-3	Benefits Payments	**Delete:** UHC and/or UBH will send you an EOB notice after processing the claim. The EOB will let you know if there is any portion of the bill you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. **Replace with:** Each month in which UHC processes at least one claim for you or a covered dependent, you will receive a Health Statement in the mail. If any claims are denied in whole or in part, you will still receive an EOB which will include the reason for the denial or partial payment. If you would rather track claims online, you may elect to discontinue receipt of paper health statements or EOBs at www.myuhc.com. You may also elect to continue to receive EOBs by making the appropriate elections online or by calling UHC Customer Service at 877-835-9855.

Effective January 1, 2008:

Entire SPD
The Following Should be Noted:
Replace all references of PharmaCare to Catalyst Rx

Section 6: Coverages/Limitations		
Pages:	Under Heading:	The Following Should be Noted:
6-10	Dental Services	**Delete:** Dental implants and implant related surgery are covered in situations where o Permanent teeth are congenitally missing (anodontia), the result of anodontia is impaired function (e.g. chewing/eating), and the implants are not done solely for cosmetic reasons o Tooth loss occurs as a result of accidental injury o Tooth loss occurs due to a medical condition such as osteoporosis or radiation of the mouth **Replace with:** Dental implants, implant related surgery, and associated crowns or prosthesis is covered in situations where… (bulleted listing remains the same)
6-11	Dental Services	**Delete:** Although dental implants and implant-related surgery may be covered as indicated above, crowns or other prosthesis required as a result of the implant are not covered. These may be covered under the Sandia Dental Deluxe/Expense Plans. **Replace with:** If you receive coverage under the medical plan for crowns or other prosthesis required as a result of implants, you cannot submit any remaining portion to the Sandia Dental Deluxe/Expense Plans for coordination of benefits.

Section 6: Coverages/Limitations		
Pages:	Under Heading:	The Following Should be Noted:
6-19	Medical Supplies	**Add the following:** You can receive coverage for aero chambers, aero chambers with masks, or nebulizers through either UHC or Catalyst Rx but not both.
6-22 and 6-23	Prescription Drugs (other than those dispensed by PharmaCare)	**Delete:** The Plan will cover enteral nutrition/prescription drugs under UHC as follows: o Enteral nutrition for: o Diagnosis of dysphasia (difficulty swallowing) o As the sole source of nutrition o In cases of the genetic disorder of Phenylketonuria (PKU) o In cases of RH factor disorders **Replace with:** The Plan will cover enteral nutrition/nutritional supplements/prescription drugs under UHC as follows: o Enteral nutrition/nutritional supplements for: o Diagnosis of dysphasia (difficulty swallowing) o As the sole source of nutrition o In cases of the genetic disorder of Phenylketonuria (PKU) o In cases of RH factor disorders o Terminal cancer You can receive coverage for nutritional supplements through either UHC or Catalyst Rx but not both.
6-23	Well-Baby Care	Routine Physical Exam will also be covered at 15 months.

Appendix A: Prescription Drug Program		
Pages:	Under Heading:	The Following Should be Noted:
A-1 to A-20		This Appendix has been replaced.

Appendix C: UHC Premier Acronyms and Definitions		
Pages:	Under Heading:	The Following Should be Noted:
C-3	Adverse Determination	**Add this definition:** When a licensed pharmacist and/or appropriate physician has performed a review and denied authorization for the requested service(s) based on the guidelines, denial of pharmacy benefits usually occurs for one of the following reasons: • The member is ineligible for requested services • The requested service is not a covered benefit • The requested service does not meet approved clinical criteria • Benefit limitations/maximum have been met
C-6 and C-7	Experimental or investigational (applicable to UHC, UBH, and PharmaCare)	This is only applicable to UHC/UBH.

Clarifications to the SPD:

Pages:	Under Heading:	The Following Should be Noted:
6-20	Obesity Surgery	**Delete:** You have documentation from a physician of a diagnosis of morbid obesity for a minimum of five years. **Replace with:** You have documentation from a physician of a diagnosis of morbid obesity for a minimum of five consecutive years.
6-24	Immunizations/ Flu Shot Services	**Delete:** The Plan will pay 100% of the eligible expense in-network and 70% of the eligible expense, after the deductible, if done out-of-network for flu shots, pneumococcal vaccine, and immunizations related to personal travel. **Replace with:** The Plan will pay 100% of the eligible expense in-network and 70% of the eligible expense, after the deductible, if done out-of-network for immunizations, flu shots, pneumococcal vaccine, and immunizations related to personal travel.
10-2 and 10-3	Benefits Payments	**Add the following:** On occasion, there are outstanding benefit payment checks that have been paid by UHC but have not been cashed and have been stale-dated. In this case, the primary covered member must notify either UHC or the Sandia Benefits Department within two calendar years from the end of the Plan year in which the service was rendered to claim funds, otherwise the monies will be forfeited.
13-2	Retiree Medical Plan Option	**Delete:** If you retire from Sandia with a service or disability pension, you are eligible for continued health coverage through Sandia under the Retiree Medical Plan Option. **Replace with:** If you retire from Sandia with a service or disability pension and you have elected to defer your pension payments, you are not eligible for continued medical coverage through Sandia under the Retiree Medical Plan Option until you begin to receive pension payments. At which time, you have 31 calendar days from the issuance of your first pension payment to elect coverage. If you do not elect within those 31 calendar days, you will need to wait until Open Enrollment. It is important to note that if you die and you and your surviving spouse (and dependents) are not covered under one of Sandia's medical plans, your surviving spouse (and dependents) will not be able to elect the Surviving Spouse Medical Plan Option. **Add the following:** If you return to work at Sandia after your initial retirement and accrue additional pension benefits towards your pension, and subsequently retire again, your medical premium-share amount will be based on the arrangements in place at the time of your subsequent retirement.

Sincerely,

Benefits Department, 3332

Sandia National Laboratories

UnitedHealthcare (UHC) Standard PPO Plan

Summary Plan Description

Effective: January 1, 2006

UnitedHealthcare Standard PPO

When you or covered family members need medical care, the UnitedHealthcare (***UHC***) Standard ***Preferred Provider Organization*** (***PPO***) Plan (referred to as the ***UHC*** Standard ***PPO)*** provides valuable financial protection. The ***UHC*** Standard ***PPO*** consists of an in-network option and an out-of-network option. This booklet provides medical benefit information to help you make more informed decisions when you or your family use this Plan. The Plan also includes the Behavioral Health Program, the Employee Assistance Program (***EAP***), and the Prescription Drug Program (***PDP***).

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

The ***UHC*** Standard ***PPO*** is a self-insured plan for eligible members and is sponsored and maintained by Sandia Corporation, 1515 Eubank SE, Albuquerque, NM, 87123 (employer identification number 85-0097942, plan number 519). This Plan is administered on a calendar-year basis from January 1 through December 31 for accumulation of maximums, ***deductibles***, claim filing, and filing of reports to the Department of Labor. ***UHC***, the ***claims administrator***, has assigned Sandia group plan number **708576**. For information concerning service of legal process, contact the Sandia Legal Division, Sandia National Laboratories, 1515 Eubank SE, MS 0141, Albuquerque, NM 87123.

The information contained in this Summary Plan Description (***SPD***) is provided in accordance with the requirements of ***ERISA*** and the Internal Revenue Code (***IRC***).

This ***SPD*** summarizes the ***UHC*** Standard ***PPO*** operations, benefits, claim filing procedures, and other Plan provisions. Copies of this document and the administrative manual are available (for a fee) from your Sandia Corporation Benefits office.

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

Contents

Section 1. Summary of Plan Changes from the Basic PPO Plan

This section highlights the changes to the Basic ***PPO*** Plan.

Summary of Changes

- UnitedHealthcare replaced United of Omaha as the ***claims administrator***.
- Provider networks are similar but not the same.
- Retirees, survivors, ***long-term disability terminees***, and their covered dependents are not eligible under this Plan.
- The in-network ***deductible*** for employees and their covered dependents increased from $650 to $1,000 for an individual and from $1,930 to $3,000 for a family of three or more.
- The out-of-network ***deductible*** for employees and their covered dependents increased from $1,200 to $2,000 for an individual and from $3,600 to $6,000 for a family of three or more.
- The out-of-network ***out-of-pocket maximum*** for employees and their covered dependents increased from $4,000 to $5,000 for an individual and from $8.000 to $10,000 for a family of two or more.
- ***Coinsurance*** is at 20 percent of ***eligible expenses*** in-network (after the ***deductible***) and 30 percent of ***eligible expenses*** out-of-network (after the ***deductible***). Out-of-network ***behavioral health*** remains at 50 percent of ***eligible expenses***, (after the ***deductible***).
- Office visits remain at a ***copay***, with the exception of laboratory, radiology, supplies, chemotherapy, radiation therapy, and medical tests, which are 20 percent of ***eligible expenses*** *(*after the ***deductible***) in-network.
- Certain in-network preventive care is covered at 100 percent of ***eligible expenses***.
- Prescription drug ***copays*** increased/decreased at retail network pharmacies as follows:
    - Generic: $9 maximum to $12 maximum
    - Preferred brand name: $17 minimum to $25 minimum and $35 maximum to $40 maximum
    - Nonpreferred brand name: $30 minimum to $40 minimum and $70 maximum to $60 maximum
- Prescription drug ***copays*** increased at mail order as follows:
    - Generic: $15 to $18
    - Preferred brand name: $43 to $65
    - Nonpreferred brand name: $75 to $100

- The provision allowing for late enrollment (beyond the 31-calendar-day period) for new hires and for new dependents of currently covered primary members has been dropped.
- Although ***primary covered members*** can still enroll a new dependent based on a birth or marriage within 31 calendar days, a copy of the birth or marriage certificate must be provided within 60 calendar days of the birth or marriage or the dependent will be disenrolled from the Plan.
- ***Primary covered members*** who have dependents covered under the Plan who are not tax dependents as identified under ***IRC*** Section 152 for purposes of health care coverage may have imputed income on the applicable premium.
- Premium-sharing changed from no premium-share to a premium-share.
- Coverage tiers for premium-sharing changed from employee only, employee plus one dependent, and employee plus two or more dependents to employee only, employee plus spouse, employee plus ***child(ren)***, and employee plus spouse and ***child(ren)***.
- ***Prior notification*** and ***precertification*** requirements have changed.
- This Plan offers United Resource Networks (***URN***) Programs for transplants, cancer services, congenital heart disease, and reproductive services. You may be eligible for additional benefits with some of these programs.
- A Disease Management Program has been added. This is a voluntary program to help members manage chronic conditions for asthma, diabetes, heart disease, low back pain, and chronic obstructive pulmonary disease.
- This Plan offers the Optum NurseLine, which gives members immediate contact with an experienced registered nurse who provides health information for routine or urgent health concerns 24 hours a day, seven days a week.

Section 2. Eligibility

This section outlines who is eligible to enroll in this Plan, who qualifies for dependent coverage under this Plan, information on ***Qualified Medical Child Support Orders*** (***QMCSOs***), and your appeal rights concerning eligibility status determinations.

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

The following groups are eligible to enroll in this Plan:

- Active employees not eligible for primary ***Medicare*** coverage
- Employees on a leave of absence and not eligible for primary ***Medicare*** coverage
- Covered member who elects temporary coverage under ***COBRA***

Covered members may be eligible for primary ***Medicare*** coverage due to end-stage renal disease. This Plan will be the primary coverage for the first 33 months (from the time you or your dependents start dialysis) which includes the 30-month coordination period with ***Medicare*** as secondary coverage. After the 30-month coordination period, ***Medicare*** will become the primary coverage, and benefits under this Plan are coordinated with ***Medicare*** as though you or your covered dependents have ***Medicare*** Parts A and B. In order to receive full benefits, you or your dependents are encouraged to enroll in ***Medicare*** Parts A and B.

Important

*If you and/or your covered dependents are eligible for **Medicare primary** coverage and are covered under this Plan (under the continuation provisions under **COBRA** or as a member with end-stage renal disease), **Medicare** is considered the primary coverage and benefits are coordinated with **Medicare** as though you and/or your covered dependents have **Medicare** Parts A and B (whether or not you and/or your covered dependents enrolled in Parts A and B). If it is later determined that you and/or your covered dependents became eligible for **Medicare primary** coverage and continued coverage under this Plan when not eligible, and Sandia paid benefits on a primary basis, the Plan will retroactively coordinate benefits with **Medicare**. If the Plan is unable to recover reimbursement from **Medicare** or the provider, the **primary covered member** will be responsible for reimbursing the Plan. Refer to Appendix A, Prescription Drug Program, for information on prescription drug coverage under this Plan and **Medicare** Part D. Refer to the booklet Medicare & You for more information. Access the booklet from **Medicare** at www.medicare.gov or 1-800-633-4227, or by calling your local Social Security office.*

Employees

You, as a Sandia employee, are eligible to enroll in this Plan. If you enroll within 31 calendar days of your hire date, your medical coverage is effective on your hire date. The following types of Sandia employees are eligible for coverage:

- Regular, full- or part-time employees as classified by Sandia for payroll purposes
- Limited-term exempt or nonexempt employees
- Faculty sabbatical appointees not eligible for other group health care coverage
- Year-round and summer student interns who are enrolled in a ***post-secondary educational program*** and not covered by another medical plan

For purposes of coverage under this Plan, an individual is eligible only if:

- He/she satisfies all requirements for coverage under the Plan
- Sandia withholds required federal, state, or FICA taxes from his/her paycheck
- Sandia issues him/her a W-2 for the year in which a medical service under the Plan is provided
- Sandia issues him/her the W-2 above no later than the year following the year in which the medical service was provided

EXCEPTIONS

An employee receiving benefits under Sandia's Job Incurred Accident Disability Plan who does not have taxes withheld by Sandia from his/her paycheck, but who otherwise satisfies the eligibility requirements of this Plan, is an employee for purposes of coverage under this Plan.

An employee on inactive status because he/she is on certain Sandia-approved leaves of absence, as evidenced by the written approval then required for such leave, who otherwise satisfies the eligibility requirement of this Plan, is an employee for purposes of coverage under this Plan.

Other Eligible Persons

You are also eligible to enroll in this Plan if you are:

- An employee on certain leaves of absence
    - An employee on inactive status because he/she is on a Sandia Corporation-approved leave of absence, as evidenced by the written approval required for such leave, who otherwise satisfied the eligibility requirements of this Plan, is a covered employee for purposes of coverage under this Plan. Refer to Section 4, Group Health Plan Premiums, for more information.

- Covered members who elect temporary coverage (***COBRA***) and pay the appropriate premium when required. Refer to Section 13, Continuation of Group Health Coverage, for more information.

Eligible Dependents

Eligible plan dependents are those individuals who are dependents of a ***primary covered member*** and any ***child*** of a ***primary covered member*** who is recognized as an ***alternate recipient*** in a ***QMCSO***.

Sandia provides coverage for two classes of dependents: Class I and Class II. Benefit provisions of this Plan generally apply to both Class I and Class II dependents except that Class II dependents are not eligible for coverage of ***substance abuse*** services under ***behavioral health*** coverage.

In general, dependents of the ***primary covered member*** who are eligible for ***Medicare primary*** coverage are not eligible for coverage under this Plan. There are exceptions to this such as a dependent of an active employee who has ***Medicare*** due to end-stage renal disease. Refer to the ***UHC*** Senior Premier ***PPO*** Plan ***SPD*** to find out if your dependent is eligible for ***Medicare primary*** coverage. Contact Sandia Health Benefits Employee Services (***HBES***) at (505) 844-4237 for information on which plans your dependent is eligible for.

Note: A dependent (other than a spouse) of an active employee or an employee on a Sandia-approved leave of absence who has ***Medicare*** due to a disability (and not age) is considered to have ***Medicare*** on a secondary basis and will continue to be covered under this Plan on a primary basis until the dependent is eligible for ***Medicare*** due to age.

Important

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

Class I Dependents

If you are the ***primary covered member*** under this Plan, your Class I dependents eligible for coverage under this Plan include dependents who are not eligible for primary ***Medicare*** coverage (unless noted under Eligible Dependents above) and include your:

- Spouse, not legally separated or divorced from you

Note: An annulment makes the spouse ineligible for coverage.

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

In addition, if you are a nonrepresented or OPEIU- or SPA-represented employee and the ***primary covered member*** under this Plan, your Class I dependents eligible for coverage also include your:

- Domestic partner who meets all of the following requirements:
    - Is the same gender as you
    - Shares significant financial resources and dependencies
    - Has resided with the you continuously for at least six months in a sole-partner relationship that is intended to be permanent
    - Is unmarried
    - Is not related to the you by blood (e.g., brothers, sisters, parents, children, cousins, nieces, uncles)
    - Is at least 18 years of age

Note: Domestic partners who attain age 65 are considered as having ***Medicare*** as their primary coverage even if enrolled as a dependent of an employee.

- Your eligible domestic partner's unmarried ***child*** under age 19
- Your eligible domestic partner's unmarried ***child*** age 19 and over, but under age 24, who is ***financially dependent*** on you
- Your eligible domestic partner's unmarried ***child*** of any age who, because of a physical or mental impairment
    - Is permanently and ***totally disabled*** and unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months

- Lives with the you, in an institution, or in a home that is provided by the primary-covered member
- Is ***financially dependent*** on you

- Your eligible domestic partner's unmarried ***child*** who is recognized as an ***alternate recipient*** in a ***QMCSO***

Class II Dependents

If you are the ***primary covered member*** under this Plan, your Class II dependents eligible for coverage under this Plan include dependents who are not eligible for primary ***Medicare*** coverage (unless otherwise noted under Eligible Dependents above) and include:

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

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

Your Class II dependents may qualify for this Plan if they:

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

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

Qualified Medical Child Support Order (QMCSO)

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 ***QMCSO***. A ***QMCSO*** is an order issued by a court or administrative agency pursuant to applicable state domestic relation laws that assigns to a ***child*** the right of a participant or beneficiary to receive benefits under an employer-provided health plan, regardless of with whom the ***child*** resides. This Plan will comply with the terms of a ***QMCSO***.

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

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

Eligibility Appeal Procedures

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

You may appeal any eligibility status determination by writing to the Employee Benefits Committee (***EBC***), Attention: Benefits Department, MS 1022. You must appeal to the ***EBC*** within 180 days of the date of the letter informing you of the eligibility status determination. The ***EBC*** has the exclusive right to interpret eligibility. The secretary of the ***EBC*** has the authority to make the final determination for appeals of an urgent nature. The determination of the ***EBC*** or its secretary is conclusive and binding.

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

Plan dependent eligibility for incapacitation is determined by the ***claims administrator***. Contact Sandia ***HBES*** for information on applying for dependent incapacitation status.

Note: If you do not enroll a dependent because he/she has other medical coverage, and that dependent involuntarily loses eligibility for that coverage, you may be able to enroll him/her in your medical plan provided that you enroll him/her within 31 calendar days after the other coverage ends. Refer to HIPAA Rights under Section 3, Enrollment and Disenrollment.

Section 3. Enrollment and Disenrollment

This section outlines the enrollment procedures for new hire employees, how to enroll and disenroll dependents, and the consequences of not disenrolling dependents in a timely manner. It also provides information on your rights under the Health Insurance Portability and Accountability Act (***HIPAA***) of 1996, the option to waive or drop coverage, and the option of disenrolling and reenrolling if you take a leave of absence, including a leave under the Family and Medical Leave Act (***FMLA***). For the events that may allow you to make a mid-year election change, see the ***Pre-tax Premium Plan*** booklet.

Note: Eligible members may elect to enroll in this Plan once a year during the ***open enrollment*** period Sandia holds each fall, with coverage effective January 1 of the following calendar year.

New Hire Employees

If you are a newly hired Sandia employee who meets the eligibility criteria as outlined in Section 2, Eligibility, you are eligible to enroll for medical coverage under this Plan. You may also elect to enroll your eligible dependents, as outlined in Section 2, Eligibility, in this Plan.

Sandia ***HBES*** will provide you a medical enrollment form (SF 4400-MED) and payroll deduction premium authorization form (SF 4811-HCC) to complete your enrollment.

Important

You must enroll yourself and your eligible dependents in this Plan within 31 calendar days of your effective hire date otherwise you will have to wait until the next ***open enrollment*** *period to enroll with coverage effective January 1 of the following calendar year. If you enroll within 31 calendar days, coverage is retroactive to your date of hire.*

To enroll in the ***UHC*** Standard ***PPO*** Plan:

- Complete the medical enrollment form (SF 4400-MED). Keep a copy as proof of coverage until you receive your ***ID*** card(s) from the ***claims administrator***.
- Complete the payroll deduction premium authorization form (SF 4811-HCC) making sure you indicate whether you want your premium to be deducted on a pre-tax or after-tax basis.

Note: Refer to Section 4, Group Health Plan Premiums, for information on whether your dependent qualifies for pre-tax health benefits.

- Mail the two forms to Sandia ***HBES*** at Mail Stop 1022 in adequate time to be received within the 31-calendar-day requirement for enrollment.

If you terminate employment and are rehired within 30 days, you (and any covered dependents at the time of disenrollment) will automatically be reinstated into the ***UHC*** Standard ***PPO*** Plan. If you terminate employment and are rehired after 30 days, you may elect to be reinstated to your prior election or you may make a new election.

Enrolling Dependents

Important

*Beginning January 1 of every year, or if you are a new enrollee, **UHC** requires an update on whether your covered dependents have other insurance. This information must be provided even if your dependents do not have other insurance. If you do not provide this information, **UHC** will pend the claim and request verification in writing from the **primary covered member** for other insurance. If you still do not provide the information, the claim will be denied. You may update your other insurance information by going online at www.myuhc.com or by calling the **UHC** Customer Service Center at 1-877-835-9855.*

Enrolling Class I Dependents

All Class I dependents you elect to have covered under this Plan must be enrolled within 31 calendar days of the event qualifying them for coverage, such as when they are newly eligible (e.g., birth, adoption, marriage, becoming an employee).

To add a domestic partner or a dependent of your domestic partner to your coverage under your medical plan, refer to the Domestic Partner packet. To access the packet, visit the Benefits home page on the internal web or contact Sandia ***HBES*** at (505) 844-4237.

Important

*If you miss the 31-calendar-day period, the next opportunity to enroll your eligible Class I dependents is during the **open enrollment** period Sandia holds in the fall, with coverage effective January 1 of the following year.*

To enroll Class I dependents in the ***UHC*** Standard ***PPO*** Plan:

- Complete the medical enrollment form (SF 4400-MED). Keep a copy as proof of coverage until you receive your ***ID*** card(s) from the ***claims administrator***.
    - All dependent information requested on the medical enrollment form (SF 4400-MED) must be provided, including:
        - Dependent's complete name and relationship to you
        - Social Security number (not applicable to newborns)
        - Date of birth and gender

- Complete the payroll deduction premium authorization form (SF 4811-HCC), making sure you indicate whether you want your premium to be deducted on a pre-tax or after-tax basis.

> **Note:** Refer to Section 4, Group Health Plan Premium, for information on whether your dependent qualifies for pre-tax health benefits.

- Mail the two forms to the Sandia ***HBES*** at Mail Stop 1022 in adequate time to be received within the 31-calendar day requirement for enrollment.

Important

*If you are enrolling an eligible dependent due to marriage or birth, you will be allowed to enroll that dependent within the required 31-calendar-day period. You must provide a copy of the marriage or birth certificate within 60 calendar days of the birth or marriage otherwise your dependent will be disenrolled. If you are enrolling an adopted **child**, you must submit the placement agreement and/or adoption papers upon enrollment, and you must enroll the adopted **child** within 31 calendar days of the placement for adoption and/or adoption. Medical expenses of the **child** before adoption, including the birth mother's prenatal, postnatal, and delivery charges, are not covered.*

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

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

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

Enrolling Class II Dependents

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

If you want to add a domestic partner or a dependent of your domestic partner to your coverage under your medical plan, refer to the Domestic Partner packet. To access the

packet, visit the Benefits home page on the internal web or contact Sandia ***HBES*** at (505) 844-4237.

Important

*If you miss the 31-calendar-day period, the next opportunity to enroll your eligible Class II dependents is during the **open enrollment** period Sandia holds in the fall, with coverage effective January 1 of the following year.*

To enroll Class II dependents in the ***UHC*** Standard ***PPO*** Plan:

- Complete the Application for Sandia Medical Care Plan Coverage for Class II Dependents form (SF 4400-CTD). Keep a copy as proof of coverage until you receive your ***ID*** card(s) from the ***claims administrator***.
    - All dependent information requested on the medical enrollment form (SF 4400-CTD) must be provided, including:
        - Dependent's complete name and relationship to you
        - Social Security number (not applicable to newborns)
        - Date of birth and gender
- Complete the Class II Dependent Affidavit form (SF-4400-CTD).
    - You will be required every December to complete the Class II Dependent Affidavit to continue coverage for your Class II dependent for the next calendar year. This form must be received by Sandia ***HBES*** by December 31 to continue coverage for the next calendar year.
- Complete the payroll deduction premium authorization form (SF 4400-CTD), indicating whether you want your premium to be deducted on a pre-tax or after-tax basis.

Note: Refer to Section 4, Group Health Plan Premium, for information on whether your dependent qualifies for pre-tax health benefits.

- Mail the three forms to the Sandia ***HBES*** at Mail Stop 1022 in adequate time to be received within the 31-calendar day requirement for enrollment.

Important

*If you are enrolling an eligible dependent due to marriage or birth, you will be allowed to enroll that dependent within the required 31-calendar-day period. You must provide a copy of the marriage or birth certificate within 60 calendar days of the birth or marriage otherwise your dependent will be disenrolled. If you are enrolling an adopted **child**, you must submit the placement agreement and/or adoption papers upon enrollment, and you must enroll the adopted **child** within 31 calendar days of the placement for adoption and/or adoption. Medical expenses of the **child** before adoption, including the birth mother's prenatal, postnatal, and delivery charges, are not covered.*

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

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

Class II Dependent	Effective Date of Coverage
Unmarried Child or Stepchild	Later of the date of the event creating eligibility or the date Benefits receives completed paperwork
Unmarried Grandchild	Later of the date of the event creating eligibility or the date Benefits receives completed paperwork. Note: If eligible due to birth or adoption or placement for adoption, the effective date is the date of the event.
Unmarried Brother or Sister	Later of the date of the event creating eligibility or the date Benefits receives completed paperwork
Parent, Step-parent, or Grandparent	Later of the date of the event creating eligibility or the date Benefits receives completed paperwork

Disenrolling Dependents

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

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

All ineligible dependents must be disenrolled within 31 calendar days of the event that has made his/her ineligible for coverage under this Plan. Plan coverage ends at the end of the month in which the dependent became ineligible.

If your premium deductions are on an after tax basis, you can disenroll your dependents at any time without a ***mid-year election change event***; however, you can only re-enroll them with a ***mid-year election change event*** or during ***open enrollment***.

If your premium deductions are on a pre-tax basis, you may disenroll your dependents within 31 calendar days of an event allowing a ***mid-year election change event*** or during the ***open enrollment*** period Sandia holds each fall. You can also disenroll dependents at any time during the calendar year if the disenrollment of the dependent does not affect your premium-share amount.

Events Causing Your Dependent to Become Ineligible

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

Class I

- Divorce or annulment
- Dissolution of domestic partnership
- Legal separation
- ***Child***, domestic partner's ***child***, marries
- ***Child***, domestic partner's ***child***, is no longer ***financially dependent***
- ***Child***, domestic partner's ***child***, no longer meets the age criteria
- Incapacitated ***child***, domestic partner's incapacitated ***child***, no longer meets incapacitation criteria
- ***Child*** who is no longer covered under a ***QMCSO***

Class II

- ***Child***, domestic partner's ***child***, step-child, grandchild, brother, or sister marries
- ***Child***, domestic partner's ***child***, step-child, grandchild, brother, sister, parent, step-parent, or grandparent no longer meets Class II eligibility requirements.

How to Disenroll Dependents

- Complete the dependent disenrollment form (SF 4400 DIS)

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

- Retain a copy for your files
- Mail the original, early enough to meet the 31-calendar-day criteria, to Sandia ***HBES*** at Mail Stop 1022.

Important

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

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

> **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***.

Sandia abides by a federal law known as the Consolidated Omnibus Budget Reconciliation Act (***COBRA***) of 1985 in which temporary continued coverage is provided to dependents who would otherwise lose group coverage due to specified

events. Refer to Section 13, Continuation of Group Health Coverage, for more information.

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

Consequence of Not Disenrolling Ineligible Dependents

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

If you do not disenroll ineligible dependents, Sandia may:

- Take employment disciplinary action up to and including termination for fraudulent use of the Plan
- Take action that results in permanent loss of health plan coverage for you and your dependents for fraudulent use of the Plan
- Report the incident to the Office of the Inspector General

If you do not disenroll ineligible dependents, Sandia will:

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

HIPAA Rights

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

These events include:

- **Loss of eligibility under another plan**. An eligible employee (and/or his/her dependents) who declined coverage when initially eligible because of having other medical coverage and who later loses the other coverage may apply for coverage for himself/herself and eligible dependents within 31 calendar days of the loss of coverage.

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

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

Waiving or Dropping Coverage in Sandia-Sponsored Medical Plans

You have the option to waive or drop coverage for yourself and your dependents. You can waive coverage when you initially become eligible to enroll in the plan or you can elect to drop coverage during the annual ***open enrollment*** period Sandia holds each fall.

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

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

How to Waive or Drop Coverage

- Complete the waiver of medical coverage form (SF 4811-WMC)
- Retain a copy for your files

- Mail the original, early enough to meet the 31-calendar-day criteria or the end of the ***open enrollment*** period, to Sandia ***HBES*** at Mail Stop 1022

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

Coverage During Leaves of Absence

Employees meeting the requirements of a leave under the Family Medical Leave Act (***FMLA***) have the option to cancel their coverage under this Plan. Written notification to cancel coverage must be received by Sandia Benefits within 31 calendar days of the first day of absence. If you choose to cancel coverage, coverage will cease at the end of the month in which Sandia Benefits receives written notification. If you do not cancel the coverage, coverage will be continued and premiums will continue to be deducted (on a pre-tax or after-tax basis) during a sickness absence, or made up upon your return from an unpaid absence.

Employees taking a non-FMLA leave of absence will receive paperwork from Sandia Benefits. If you wish to continue coverage under this Plan, you will be responsible for paying your monthly premiums on an after-tax basis. If you do not pay your premiums during a non-FMLA leave of absence, your coverage will be canceled.

If you do not cancel your coverage under this Plan during a sickness absence or an unpaid absence and you return in a subsequent calendar year, premiums not taken will be made up on an after-tax basis.

An employee can reenroll in this Plan by requesting enrollment and notifying Sandia Benefits in writing within 31 calendar days of return to work from the leave of absence. If you do not reenroll in this Plan by notifying Sandia Benefits, in writing, within 31 calendar days of your date of return from leave, you cannot reinstate your medical coverage until the following ***open enrollment*** period Sandia holds in the fall.

Important

If you have waived medical coverage for yourself and your dependents while still employed with Sandia, and then terminated employment without coverage, you and your dependents are not eligible for ***COBRA*** *continuation.*

Mid-Year Election Change Events

Certain events may permit a change to your health care coverage at times other than during ***open enrollment***. Refer to the ***Pre-tax Premium Plan*** booklet for more information.

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

Section 4. Group Health Plan Premiums

This section outlines how premiums are charged for the various classifications of members who are eligible for coverage under a ***Sandia-sponsored medical plan***.

Important

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

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

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

Important

*It is the responsibility of each **primary covered member** to determine whether his/her covered dependents meet the plan eligibility requirements of Sandia's plans and the tax dependent rules of the **IRC**. Should the IRS audit your tax return and determine you have obtained tax benefits for which you are ineligible, you will be responsible for any overdue taxes, interest and penalties.*

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

Monthly Premium Payment for Coverage

In most instances, Sandia requires a monthly premium payment for coverage of eligible individuals under the ***UHC*** Standard ***PPO*** Plan. If you are required to pay a premium, the monthly premium share amount will be deducted from the employee's biweekly pay-check in two equal installments each month. Other eligible covered persons pay Sandia in a direct payment.

> **Note:** Health care premiums, whether taken on a pre- or after-tax basis, are not allowed as reimbursable expenses under the ***Health Care Reimbursement Spending Account***.

Employee Premium

Current employee premiums for continued coverage under this Plan are provided during the ***open enrollment*** period Sandia holds each fall, through Sandia ***HBES*** at (505) 844-4237, and online at www-irn.sandia.gov/hr/benefits/health/premiumindex.htm.

All employees pay a monthly premium for coverage under this Plan. Monthly premium payments are set according to the employee's base salary tier, coverage tier, and the plan the employee selects. The Class I dependent premiums are included in the employee premium share amount taken through payroll deductions.

The premium share is based upon the following family structure:

- Employee only
- Employee and ***child(ren)***
- Employee and spouse
- Employee, spouse, and ***child(ren)***

Sandia currently has three salary tiers for premium share purposes:

- Tier 1 – Base salary of up to $75,000 as of January 1
- Tier 2 – Base salary of $75,001 to $150,000 as of January 1
- Tier 3 – Base salary of over $150,000 as of January 1

The premium share for the calendar year is based on your base salary as of January 1. If your base salary changes during the year and you are bumped into another tier, your premium share will not change for the remainder of the year. Employees working part time (at least 24 hours per week) pay the applicable premium share based on their prorated salary as of January 1; however, part-time employees working fewer than 24 hours per week will pay one-half of the full premium cost (regardless of when they began the work schedule of fewer than 24 hours per week).

Note: Represented employees should refer to their applicable union agreements for premium sharing information.

If your effective coverage date is prior to the 17th of the month, you are required to pay the applicable cost-share amount for the month in which you became eligible for coverage under this Plan. If your effective coverage date is on the 17th of the month or later, you are not required to pay the cost-share amount for the month in which you became eligible for coverage under this Plan.

Dual Sandians

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

Note: Under this Plan, employees, retirees, or eligible dependents cannot be covered as both a ***primary covered member*** and a dependent, or as a dependent of more than one ***primary covered member***.

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

Class II Dependent Premium

Class II dependents you enrolled prior to 1987 are included in the premium share you pay for yourself and your covered Class I dependent. Any Class II dependents you enrolled after 1986 will not be counted as dependents in calculating the family premium, and you will pay a separate Class II premium. Refer to the ***open enrollment*** booklet or the Benefits home page on the internal web, or call Sandia ***HBES*** at (505) 844-4237 for premium share information.

Domestic Partner Premium

Benefits paid under a group health plan for a covered domestic partner, or for covered dependents of a domestic partner, who would not qualify as a tax dependent under the ***IRC*** for purposes of health care coverage, cause the employee to receive additional compensation as taxable wages. The employee is required to declare as taxable income the value of the domestic partner and his/her domestic partner's dependents as imputed income. Imputed income is not a pay increase. It is the value of Sandia's contributions for health coverage for dependents who are not your tax dependents. The imputed income will be added to the employee's gross income and will be subject to FICA (Social Security and ***Medicare***) and income taxes, and reported on his/her annual W-2.

> **Note:** Premiums for domestic partners and dependents of domestic partners will automatically be deducted on an after-tax basis and imputed income will be added to your pay UNLESS you contact Sandia ***HBES*** and complete an Affidavit of Tax Status to allow them to be designated as tax dependents under ***IRC*** Section 152 for purposes of health care coverage.

For information on specific premium-sharing provisions for domestic partners, refer to the Domestic Partner packet on the Benefits internal web home page or contact Sandia ***HBES*** at (505) 844-4237 for a copy.

Pre-tax Premium Plan

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

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

Note: Check your pay stub to determine whether your premiums are being taken on a pre-tax or after tax basis.

Important

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

Leaves of Absence

Child and Family Care – Sandia pays the employer portion of the premiums for continued health care coverage during the first six months of your leave of absence. You pay the full premium for continued employer-group health care coverage beyond that time.

If you do not continue your employer-group health care coverage during your leave, you will need to reenroll to reinstate that coverage within 31 calendar days of returning from your leave.

Tribal Government Appointees – Sandia pays the employer portion of the premiums for continued employer group health care coverage during the period of the leave of absence.

If you do not continue your employer-group health care coverage during your leave, you will need to reenroll to reinstate that coverage within 31 calendar days of returning from your leave.

Military Service – Sandia pays the employer portion of the premiums for continued employer group health care coverage during the first six months of the leave of absence. You pay the full premium for continued employer group health care coverage beyond that time.

If you do not continue your employer-group health care coverage during your leave, you will need to reenroll to reinstate that coverage within 31 calendar days of returning from the leave.

All other leaves – Your employer-group health care coverage stops at the end of the month in which your leave of absence begins. You are eligible to continue that coverage by paying the full premium, plus a two percent administrative fee, for the duration of your approved leave of absence.

If you do not continue your employer-group health care coverage during your leave, you will need to reenroll to reinstate that coverage within 31 calendar days of returning from your leave.

COBRA Premium

Sandia requires those who elect continuation of the employer-provided health coverage to pay the full cost of the coverage, plus a two percent administrative charge. The required ***COBRA*** premium is more expensive than the amount active employees pay, but the ***COBRA*** premium may be less expensive than individual health coverage. ***COBRA*** continuation coverage lasts only for a limited period of time. See Section 13, Continuation of Group Health Coverage, for more information.

As an alternative to electing coverage under the Retiree, ***Long-term Disability Terminee***, or Surviving Spouse Medical Plan Options, those individuals may choose to continue the active employee health plan coverage by making a ***COBRA*** election. See Section 13, Continuation of Group Health Coverage, for more information.

Section 5. Deductibles and Maximums

This section summarizes the annual ***deductibles*** and ***out-of-pocket maximums*** that apply to the in-network option and the out-of-network option, as well as any lifetime maximums under the Plan.

Note: Members who do not have access to ***UHC*** network providers within a 30-mile radius of their home will be covered under the in-network level of benefits under the ***out-of-area plan*** when they access providers. ***UHC*** determines who will be placed in the ***out-of-area plan***. Reimbursement is based on billed charges.

Deductibles

A member must first pay the annual ***deductible*** before the Plan begins to pay for covered health care services (with the exception of certain services such as office visits). When the member meets the full ***deductible*** amount, the Plan begins to pay for eligible, covered expenses at the applicable ***coinsurance*** amount.

General Information	In-Network Option			Out-of-Network Option		
Annual Deductible	Individual	Family of two	Family of three or more	Individual	Family of two	Family of three or more
	$1,000	$2,000	$3,000	$2,000	$4,000	$6,000

Payments Not Applied to Deductible

Copayments, amounts above ***eligible expenses***, charges not covered by the Plan, prescription drug ***copays***, and charges incurred because of failure to obtain required ***precertification*** or ***prior notification*** do not apply toward the ***deductible***.

Family Deductible

Each family member may contribute toward the family ***deductible*** based on Plan usage. However, contribution maximums are limited to the individual ***deductible*** amount.

After three members in a family of three or more meet the individual ***deductible***, the family ***deductible*** is satisfied. No more than the individual ***deductible*** amount will be applied to the family maximum per member.

EXAMPLE: An employee has a family of five members. The in-network ***deductible*** for this family is $3,000. During the calendar year, the father and mother each incurred out-of-network expenses of $1,000 and $500, respectively. The three children incurred in-

network expenses as follows: first child, $500; second child, $1,000; third child, $200. These expenses are determined to be covered charges and are applied to the ***deductible*** by the ***claims administrator*** in the order of receipt of the claims. The individuals contribute to the ***deductible*** as follows:

In-Network Deductible Example			
	Expenses Incurred	**Individual Plan Limit**	**Allowable Contribution**
Father	$1,000	$1,000	$1,000
Mother	$500	$1,000	$500
1st Child	$500	$1,000	$500
2nd Child	$1,000	$1,000	$1,000
3rd Child	$200	$1,000	$0
		Total:	**$3,000**

After these charges are applied to the family ***deductible***, no additional charges are applied even though some family members have not met the individual ***deductible***.

Out-of-Pocket Maximum

General Information	**In-Network Option**		**Out-of-Network Option**	
Annual Out-of-Pocket Maximum	Individual	Family of two or more	Individual	Family of two or more
	$2,500	$5,000	$5,000	$10,000

With some exceptions (outlined in the table below), no additional ***coinsurance*** will be required for the remainder of the calendar year:

- For the member: when a member uses the in-network option and incurs his/her in-network ***out-of-pocket maximum*** for covered medical expenses
- For the family: when the family uses the in-network option and incurs their in-network ***out-of-pocket maximum*** for covered medical expenses
- For the member: when a member uses the out-of-network option and incurs his/her out-of-network ***out-of-pocket maximum*** for covered medical expenses
- For the family: when the family uses the out-of-network option and incurs their out-of-network ***out-of-pocket maximum*** for covered medical expenses

Important

*The **out-of-pocket maximums** do not cross apply between in-network and out-of-network. **UHC** will notify members via an explanation of benefits (**EOB**) notice when the **out-of-pocket maximum** has been reached.*

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

Plan Features	Applies to the In-Network, Out-of-Pocket Maximum?	Applies to the Out-of-Network, Out-of-Pocket Maximum?
Copays	No	Not applicable
Payments toward the annual deductible	Yes	Yes
Member coinsurance payments	Yes	Yes
Charges for noncovered health services	No	No
Amounts of any reductions in benefits you incur by not following prior notification or precertification requirements	No	No
Amounts you pay toward behavioral health services	Yes	No
Charges that exceed eligible expenses	Not applicable	No
Prescription drugs obtained through PharmaCare	No	No

EXAMPLE: In a calendar year, a family of three meets the in-network family $5,000 ***out-of-pocket maximum*** as follows:

Out-of-Pocket Maximum In-Network Example			
	Out-of-Pocket Expenses In-Network	**Applied to Out-of-Pocket In-Network**	**Applied to Out-of-Pocket Out-of-Network**
Employee	$2,500	$2,500	$0
Spouse	$2,500	$2,500	$0
1st Child	$0	$0	$0
Total:	**$5,000**	**$5,000**	**$0**

For the remainder of the calendar year, any additional covered medical expenses submitted by this family under the in-network option will be paid at 100 percent of ***eligible expenses*** (with some exceptions). If any member of this family, however, seeks out-of-network care, the in-network ***out-of-pocket maximum*** will not apply.

EXAMPLE: In a calendar year, a family of three meets the out-of-network family $10,000 ***out-of-pocket maximum*** as follows:

Out-of-Pocket Maximum Out-of-Network Example			
	Out-of-Pocket Expenses Out-of-Network	**Applied to Out-of-Pocket Out-of-Network**	**Applied to Out-of-Pocket In-Network**
Spouse	$5,000	$5,000	$0
1st Child	$4,000	$4,000	$0
2nd Child	$1,000	$1,000	$0
Total:	**$10,000**	**$10,000**	**$0**

For the remainder of the calendar year, any additional covered medical expenses submitted by this family under the out-of-network option will be paid at 100 percent of ***eligible expenses*** (with some exceptions). If any member of this family, however, seeks in-network care, the out-of-network ***out-of-pocket maximum*** will not apply.

Lifetime Maximums

The Plan does not have any lifetime maximums, with the exception of the infertility benefit as described below.

Reaching the Infertility Maximum of $30,000

When the covered member reaches the $30,000 lifetime maximum benefit, no additional reimbursement for any procedures incurred to treat infertility are payable. Other covered procedures related to family planning or reproduction (excluding infertility) may be payable. Refer to Section 6, Coverages/Limitations.

Section 6. Coverages/Limitations

The ***UHC*** Standard ***PPO*** provides a wide range of medical care services for you and your family. The following table details coverage under this Plan. The in-network option requires you to obtain care from ***UHC*** or United Behavioral Health (***UBH***) networks, and the out-of-network option allows you to seek care from any licensed provider. For detailed explanations of what is covered under the benefit, refer to the information following the table.

Note: This Plan does not have any pre-existing condition limitations.

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

- Provided to prevent, diagnose, or treat ***sickness***, ***injury*****,** mental illness, ***substance abuse***, or their symptoms
- Included in this section (subject to limitations and conditions and exclusions as stated in this ***SPD***)
- Provided to a covered member who meets the Plan's eligibility requirements as described in Section 2, Eligibility
- ***Medically appropriate***

Note: If a health service is not listed in this section as a covered health service, or listed in the Exclusion Section as a specific exclusion in the Plan, it may or may not be a covered health service. Contact ***UHC*** Customer Service at 1-877-835-9855 for information.

Plan Highlights

The following tables highlight the amounts you will pay for various covered health services. A ***copayment*** is a cost-sharing feature by which the Plan pays the remainder of the covered charge after the member pays his/her portion as a defined dollar amount (e.g., $15 ***copay*** for primary care ***physician's*** office visit).

Note: ***Copayments*** are not subject to the ***deductible***.

Coinsurance is a cost-sharing feature by which both the Plan and the member pay a percentage of the ***eligible expense***. For in-network services, the ***coinsurance*** (e.g., 20 percent) is the percentage of ***eligible expenses*** you pay (after the ***deductible*** has been met). For out-of-network services, the ***coinsurance*** (e.g., 30 percent) is the percentage of ***eligible expenses*** you pay after the ***deductible*** has been met.

Important

*You are responsible for the amount above **eligible expenses** if you receive services out-of-network.*

Notes: Members who do not have access to ***UHC*** network providers within a 30-mile radius of their home will be covered under the in-network level of benefits under the ***out-of-area plan*** when they access providers. ***UHC*** determines who will be placed in the ***out-of-area plan***. Reimbursement is based on billed charges.

This Plan has a ***Network Gap Exception*** provision for covered health services. Under this provision, if there are no in-network providers in the required specialty within a 30-mile radius from the member's home, contact ***UHC*** to request an exception under this provision to allow in-network benefits for services provided by an out of network provider.

Important

*Some services require **prior notification,** notification, or **precertification**, otherwise you will receive reduced benefits or, in certain cases, no benefits. For a complete listing of these services, refer to Section 8, Accessing Care.*

Benefit	In-Network Option	Out-of-Network Option
Acupuncture Services	20%	30%
Allergy Services – office visit – testing – serum – allergy shot	 $15 if PCP; $25 if specialist $15 if PCP; $25 if specialist 20% 20%	 30% 30% 30% 30%
Ambulance	**Prior Notification Required for Air Ambulance** 20%	**Prior Notification Required for Air Ambulance** 30%
Behavioral Health (Mental Health and Substance Abuse Program)	**Precertification required for neuropsychological testing, inpatient services, partial hospitalization, intensive outpatient stays/programs and residential treatment** 20%	**Precertification required for neuropsychological testing, inpatient services, partial hospitalization, intensive outpatient stays/programs and residential treatment** 50%*
Important *For detailed benefit provisions, including any limits that may apply, refer to the information following this table. Refer to Section 7 for exclusions.*		

* Does not apply to the out-of-pocket maximum

Benefit	In-Network Option	Out-of-Network Option
Biofeedback Services	20%	30%
Chemotherapy – physician's office – outpatient facility – inpatient facility	 20% 20% 20%	 30% 30% 30%
Chiropractic Services	20%	30%
Dental Services – physician's office – outpatient facility – inpatient facility	**Prior Notification Required** $25 copay per visit 20% 20%	**Prior Notification Required** 30% 30% 30%
Diagnostic Tests – physician's office – outpatient facility – inpatient facility	 20% 20% 20%	 30% 30% 30%
Durable Medical Equipment	**Prior Notification Required if $1,000 or more** 20%	**Prior Notification Required if $1,000 or more** 30%
Emergency Room Care	20%	**True emergency** 20% of billed charges **Nonemergency** 30%
Employee Assistance Program (EAP)	**Precertification Required** Up to eight visits per year at no cost to you	Not available
Eye Exam for nonrefractive care due to sickness or injury to the eye	$15 if PCP; $25 if specialist	30%
Eyeglasses/Contact Lenses	20%	30%
Family Planning – physician's office – outpatient facility – inpatient facility	 $15 if PCP; $25 if specialist 20% 20%	 30% 30% 30%
Hearing Aids/Exam – exam – hearing aid	 $15 if PCP; $25 if specialist 20% **Note:** Hearing exams for well-baby and well-child care as outlined under the preventive benefit will be covered at no cost to the member.	 30% 30%
Important *For detailed benefit provisions, including any limits that may apply, refer to the information following this table. Refer to Section 7 for exclusions.*		

Benefit	In-Network Option	Out-of-Network Option
Home Health Care	**Prior Notification Required** 20%	**Prior Notification Required** 30%
Hospice Services	**Prior Notification Required** 20%	**Prior Notification Required** 30%
Infertility Treatment – physician's office – outpatient facility – inpatient facility	 $25 copay 20% 20%	 30% 30% 30%
Injections in Physician's Office – allergy shots – immunizations/ vaccinations – all other injections	 20% No cost to you $15 if PCP; $25 if specialist	 30% 30% 30%
Inpatient Services	**Prior Notification Required** 20%	**Prior Notification Required** 30%
Lab – inpatient – outpatient – physician's office	 20% 20% 20%	 30% 30% 30%
Maternity – initial visit to determine pregnancy status – delivery, prenatal and postnatal care – nursery care for well-baby newborn	**Notification may be required (refer to page 6-18)** $15 if PCP; $25 if specialist 20% 20%	**Notification may be required (refer to page 6-18)** 30% 30% 30%
Medical Supplies	20%	30%
Nutritional Counseling	20%	30%
Office Care – primary care physician – specialist	 $15 per visit $25 per visit	 30% 30%
Important *For detailed benefit provisions, including any limits that may apply, refer to the information following this table. Refer to Section 7 for exclusions.*		

Benefit	In-Network Option	Out-of-Network Option
Organ Transplant	**Prior Notification Required** 20%	**Prior Notification Required** 30%
Outpatient Surgery – physician's office – outpatient facility	 $15 if PCP; $25 if specialist 20%	 30% 30%
Prescription dispensed other than at pharmacy i.e., physicians office	20%	30%
Preventive Care	No cost to you	30%
Prosthetic Appliances	20%	30%
Radiation Therapy – physician's office – outpatient facility – inpatient facility	 20% 20% 20%	 30% 30% 30%
Radiology – inpatient – outpatient – physician's office	 20% 20% 20%	 30% 30% 30%
Rehabilitation Services (Outpatient) – physical therapy – occupational therapy – speech therapy – pulmonary rehabilitation – cardiac rehabilitation	 20% 20% 20% 20% 20%	 30% 30% 30% 30% 30%
Skilled Nursing Facility/ Inpatient Rehabilitation Facility	**Prior Notification Required** 20%	**Prior Notification Required** 30%
Urgent Care Facilities	20%	30%
Important *For detailed benefit provisions, including any limits that may apply, refer to the information following this table. Refer to Section 7 for exclusions.*		

Additional Coverage Details

While the tables on the previous pages provide information about the coverage levels you will pay, the following information provides detailed descriptions of the covered health services as defined on Page 6-1. Refer to Section 7, Exclusions, for information on what is excluded from coverage under the Plan.

Acupuncture Services

The Plan covers acupuncture services as follows:

- X-rays and other services provided by a licensed acupuncturist or doctor of oriental medicine, either in- or out-of-network, with no review by ***UHC*** required
- Any combination of in-network and out-of-network benefits for acupuncture and chiropractic services is limited to 10 visits per calendar year per covered member. This maximum applies to in- and out-of-network acupuncture and chiropractic benefits combined.

Allergy Services

The Plan covers services related to allergies as follows:

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

Ambulance Services

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

Ground Ambulance Services

- ***emergency*** transportation to the nearest ***hospital*** where ***emergency*** health services can be performed is paid at the in-network level of benefit
- transportation from one facility to another is considered as an ***emergency*** when ordered by the treating ***physician***
- if there is documentation from the ambulance service provider that it does not differentiate between advanced life support and basic life support, the Plan will cover the services as billed

Air Ambulance Services

> ***Prior notification*** to Care Coordination℠ is required at least five business days before receiving services, or in an ***emergency*** within two business days after receiving services, or as soon as reasonably possible. If Care Coordination℠ is not notified, benefits will be reduced by $300. See Section 8, Accessing Care, for more information.

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

Nonemergency ambulance services (e.g., home to ***physician*** for an office visit, etc.) are not covered.

Behavioral Health Services

Precertification to ***UBH*** is required before receiving services for neuropsychological testing, intensive ***outpatient*** therapy programs, ***partial hospitalization***, ***inpatient stays***, and ***residential treatment facilities*** as follows:

- For nonemergency services: at least five business days before admission
- For ***emergency*** services: within two business days, or as soon as is reasonably possible

If services are not precertified, benefits will be reduced by $300. Refer to Section 8, Accessing Care, for more information.

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

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

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

- Services received on an inpatient or ***partial hospitalization*** basis in a ***hospital*** or an alternate facility that is licensed to provide mental health or ***substance abuse*** treatment
- If a member is admitted to a facility and the patient does not meet inpatient criteria, ***UBH*** will review to determine whether the patient meets ***partial hospitalization*** criteria. If the member does meet ***partial hospitalization*** criteria, only the cost for ***partial hospitalization*** in that area will be allowed, with the ***primary covered member*** responsible for the remainder of the cost.
- Room and board in a semi-private room (a room with two or more beds)

> **Note:** The Plan will pay the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice as determined by United Behavioral Health.

- Two ***partial hospitalization*** days are counted as one 24-hour hospitalization day

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

- 30 days of the 60-day inpatient day maximum per calendar year, with the exception of 45 days allowed out of the 60 days for eating disorders
- Up to 90 days of the inpatient day maximum in any five consecutive calendar-year time frame
- To be considered a residential stay, there must be at least six hours of therapy provided every calendar day

Important

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

Guidelines

- The Plan allows up to 20 ***outpatient*** mental health and ***substance abuse*** visits per calendar year.
- Any combination of in-network and out-of-network benefits for mental health services and/or ***substance abuse*** services is limited to 60 days per calendar year (unless as otherwise mentioned).
- Types of services that are rendered as a medical service, such as lab or radiology, are paid under the medical benefits.
- If there are multiple diagnoses, the Plan will only pay for treatment of the diagnoses that are identified in the current edition of the *Diagnostic and Statistical Manual* of the American Psychiatric Association.

Biofeedback Services

The Plan covers biofeedback services as follows:

- For pain, urinary, and fecal incontinence
- Up to five biofeedback sessions per lifetime for smoking cessation
- Charges incurred for training
- Charges billed by a licensed chiropractor, physical therapist, occupational therapist, medical doctor, or doctor of osteopathy
- Charges from other providers will be reviewed for medical appropriateness.

Cancer Services

UHC provides Plan members with access to designated United Resource Networks (***URN***) facilities through the Cancer Resource Services Program. It is not mandatory that you receive services through this Program but if you do you may be eligible for additional benefits. Refer to Section 8, Accessing Care, for more information.

The Plan covers oncology services as follows:

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

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

Cancer clinical trials and related treatment and services may be eligible for coverage under this Plan for members enrolled in the Cancer Resource Services Program. Such treatment and services must be recommended and provided by a ***physician*** in a designated ***URN*** facility through this Program. The cancer center must be a participating center in the Cancer Resource Services Program at the time the treatment or service is given. For more information, contact Care Coordination at 1-877-835-9855.

Note: The services described under Travel and Lodging in Section 8, Accessing Care, are covered health services only in connection with cancer-related services received at a designated United Resource Networks facility through the Cancer Resource Services Program.

Chiropractic Services

The Plan covers chiropractic services as follows:

- X-rays and other services provided by a licensed chiropractor or doctor of oriental medicine, either in- or out-of-network, with no review by ***UHC*** required
- Any combination of in-network and out-of-network benefits for acupuncture and chiropractic services is limited to 10 visits per calendar year per covered member. This maximum applies to in- and out-of-network acupuncture and chiropractic benefits combined.

Dental Services

> ***Prior notification*** to Care Coordination℠ is required at least five business days before follow-up (post-emergency) treatment begins. If Care Coordination℠ is not notified, benefits will be reduced by $300. You do not have to provide notification before the initial ***emergency*** treatment. Refer to Section 8, Accessing Care, for more information.

The Plan covers dental services due to a ***sickness*** or ***injury*** when provided by a doctor of dental surgery (DDS) or doctor of medical dentistry (DMD) as follows:

- As a result of accidental ***injury*** to sound, natural teeth and the jaw
- As a result of tooth or bone loss due to a medical condition (e.g., osteoporosis, radiation to the mouth, etc.)
- Oral surgery if performed in a ***hospital*** because of a complicating medical condition that has been documented by the attending ***physician***
- Anesthesia, ***hospital***, and/or ambulatory surgical center expenses for dental procedures when services must be provided in that setting due to disability or for young ***children*** as determined by the attending ***physician***
- Dental implants and implant related surgery are covered in situations where
    - permanent teeth are congenitally missing (anodontia), the result of anodontia is impaired function (e.g., chewing/eating), and the implants are not done solely for cosmetic reasons
    - tooth loss occurs as a result of accidental ***injury***
    - tooth loss occurs due to a medical condition such as osteoporosis or radiation of the mouth
- Orthognathic surgery limited to documented skeletal Class II and Class III conditions as determined by cephalometric diagnosis, provided the condition is:
    - both functional and aesthetic
    - not adequately treatable by conventional orthodontic therapy
- Dental services related to medical transplant procedures

- Initiation of immunosuppressive therapy
- Direct treatment of cancer or cleft palate

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

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

Diagnostic Tests

The Plan covers diagnostic tests as follows:

- Laboratory and radiology
- Computerized tomography (CT) scans
- Position emission tomography (PET) scans
- Magnetic resonance imaging (MRI)
- Nuclear medicine
- Echocardiograms
- Electroencephalograms
- Sleep studies
- Other diagnostic tests

Durable Medical Equipment (DME)

> ***Prior notification*** to Care Coordination℠ is required at least five business days before purchase or rental of ***DME*** for items with a purchase or cumulative rental value of $1,000 or more. If Care Coordination℠ is not notified, benefits will be reduced by $300. Refer to Section 8, Accessing Care, for more information.

The Plan covers ***durable medical equipment*** (***DME***) as follows:

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

- Appropriate for use in the home

Important

*For items with a purchase or cumulative rental value of $1,000 or more, Care Coordination℠ will decide if the equipment should be purchased or rented, and you must purchase or rent the **DME** from the vendor Care Coordination℠ identifies.*

Examples of ***DME*** include but are not limited to:

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

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

The Plan will allow more than one piece of ***DME*** if deemed ***medically appropriate*** by Care Coordination℠ (e.g., an oxygen tank in the home and a portable oxygen tank).

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

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

Emergency Care

Important

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

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

- ***Emergency*** services obtained from an in-network provider will be considered at the in-network level of benefits if it is a ***medical emergency***.

> **Note:** Nonemergency services received in an in-network ***hospital emergency*** room will be covered at the applicable in-network benefit.

- ***Emergency*** services obtained from an out-of-network provider will be considered at the in-network level of benefits if it is a ***medical emergency***.

> **Note:** Nonemergency services received in an out-of-network ***hospital emergency*** room will be covered at the applicable out-of-network benefit.

- If you receive ***emergency*** care outside the United States, you will be eligible for reimbursement at the in-network level of benefits.
- Follow-up care that results from a ***medical emergency*** while on travel outside the United States will be covered at the in-network level of benefit.
- Follow-up care that results from a ***medical emergency*** while on travel within the United States will be covered at the in-network level of benefits only if the place of care is not located within 30 miles of any in-network provider.
- If you are hospitalized in an out-of-network ***hospital***, you will be transferred to an in-network ***hospital*** when medically feasible, with any ground ambulance charges reimbursed at the in-network level of benefits. If you decline to be transferred, coverage will be provided under the out-of-network benefit level.

> **Note:** Expenses for health care services that you should have received before leaving the ***service area*** or that could have been postponed safely until your return are eligible for coverage at the out-of-network benefit level.

Employee Assistance Program (EAP)

Precertification to ***UBH*** is required to be eligible to receive offsite ***EAP*** benefits. Refer to Section 8, Accessing Care, for more information.

The Plan covers up to eight visits (in-network only) per calendar year at no cost to the employee for assessment, referral, and follow-up counseling for employees and their covered dependents experiencing some impairment from personal concerns that adversely affects their day-to-day activities. Such concerns include but are not limited to:

- Health
- Marriage
- Family
- Finances
- ***Substance abuse***
- Legal issues
- Stress

Eye Exam/Eyeglasses/Contact Lenses

The Plan covers eye exams for nonrefractive care due to ***sickness*** or ***injury*** of the eye such as conjunctivitis, diabetic retinopathy, glaucoma, and cataracts. The Plan pays for an initial pair of contact lenses or glasses when required due to the loss of a natural lens or cataract surgery.

Employees and their covered dependents who are enrolled in the Sandia Vision Care Plan are eligible to receive services related to refractive care under that plan.

Family Planning

The Plan covers family planning services as follows:

- Sterilization procedures such as vasectomies and tubal ligations
- ***Medically appropriate*** ultrasounds and laparoscopies
- Family planning devices that are implanted or injected by the ***physician*** such as ***IUDs***, Norplant, or Depo-provera
- Reversals of prior sterilizations
- Surgical, nonsurgical, or drug-induced pregnancy termination
- Health services and associated expenses for elective and therapeutic abortion

Diaphragms and any other birth control obtained at a pharmacy are eligible for coverage under PharmaCare.

Hearing Aids/Exam

The Plan covers the initial hearing exam and purchase of hearing aid if the hearing loss resulted from a sudden ***injury*** or a ***sickness***. Refer to the Preventive Care benefits in this section for information on hearing screenings.

Home Health Care Services

> ***Prior notification*** to Care Coordination℠ is required at least five business days before receiving services. If Care Coordination℠ is not notified, benefits will be reduced by $300. Refer to Section 8, Accessing Care, for more information.

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

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

Hospice Services

> ***Prior notification*** to Care Coordination℠ is required at least five business days before receiving services. If Care Coordination℠ is not notified, benefits will be reduced by $300. Refer to Section 8, Accessing Care, for more information.

The Plan covers ***hospice*** care as follows:

- Provided on an inpatient basis
- Provided on an ***outpatient*** basis
- Physical, psychological, social, and spiritual care for the terminally ill person
- Short-term grief counseling for immediate family members

Benefits are available only when ***hospice*** care is received from a licensed ***hospice*** agency or ***hospital***.

Infertility Services

UHC provides to those members eligible for infertility benefits access to designated United Resource Networks facilities through the Reproductive Resource Services Program. It is not mandatory that you receive services through this Program, but if you do, you may be eligible for additional benefits. Refer to Section 8, Accessing Care, for more information.

In general, the Plan pays benefits for infertility services and associated expenses for the diagnoses and treatment of an underlying medical condition that causes infertility, when under the direction of a ***physician***.

Important

A maximum lifetime benefit of $30,000 per covered member is allowed for infertility treatments. This maximum is accumulated from any expenses related to infertility treatment paid following a confirmed diagnosis of infertility. Infertility treatments are covered only with a confirmed diagnosis of infertility. Expenses for infertility services incurred without a diagnosis of infertility will not be reimbursed. There are limitations to eligible procedures (refer to Section 7, Exclusions, for more information).

The maximum lifetime benefit does not include expenses related to diagnosing infertility, testing relating to determining the cause of infertility or the diagnosis and treatment of an underlying medical condition (e.g., endometriosis) that causes infertility. However, testing and treatments after a confirmed diagnosis of infertility will be applied to the $30,000 lifetime maximum such as:

- ***Medically appropriate*** laparoscopies and ultrasounds
- Artificial insemination
- Gamete intrafallopian transfers (***GIFT***)
- Embryo transplantation
- Laparoscopies for egg retrieval
- Purchase of sperm, if billed separately
- Limited donor expenses for egg donor (only the same charges that would be eligible to extract the egg from a covered employee are allowed for the donor; prescription medications taken by a donor are not allowable charges.)
- Storing and preserving embryos for up to two years

Prescription Drugs for Infertility Treatments

Prescription drugs related to infertility are covered under the Prescription Drug Program. Prescription drugs obtained through the Prescription Drug Program and used for infertil-

ity treatment may require a diagnosis of infertility. The cost of these drugs is not applied to the $30,000 infertility maximum if received through the Prescription Drug Program.

EXCEPTION

If the prescription drug or device is provided by the ***physician*** and billed through the provider's office or facility charges, ***UHC*** will review the charge to determine eligibility for reimbursement. If categorized as an infertility treatment, the charges will be applied to the $30,000 maximum. These charges may also be applied to the appropriate Plan ***deductibles*** and ***out-of-pocket maximums***. Neither the Prescription Drug Program nor this Plan covers prescriptions for donors.

Injections in Physician's Office

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

- In-network
  - Allergy shots – 20 percent of ***eligible expenses,*** after the ***deductible***
  - Immunizations/vaccines – no cost to you as outlined under the Preventive Care benefit in this Section
  - All other injections (e.g., cortisone, depo-provera, etc.) – $15 if in ***PCP*** office, $25 if in ***specialist*** office
- For out-of-network services, you pay 30 percent of ***eligible expenses***, after the ***deductible***

Inpatient Care

Prior notification to Care Coordination℠ is required as follows:

- For nonemergency admissions: at least five business days before admission
- For ***emergency*** admissions: within two business days, or as soon as is reasonably possible

If Care Coordination℠ is not notified, benefits will be reduced by $300. Refer to Section 8, Accessing Care, for more information.

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

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

Note: The Plan will pay the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice as determined by ***UHC*** or ***UBH***.

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

If a member is admitted to a ***hospital*** on an ***emergency*** basis that is not in the network and services are covered, in-network benefits will be paid until the patient is stabilized. Once stabilized, the patient must be moved to a network ***hospital*** to continue in-network benefits. The patient may elect to remain in the out-of-network ***hospital*** and receive out-of-network benefits, as long as ***UHC/UBH*** confirms the treatment to be ***medically appropriate***.

Maternity Services

Newborn and Mother's Health Protection Act: Under federal law, mothers and their newborns who are covered under group health plans are guaranteed a stay in the ***hospital*** of not less than 48 hours following a normal delivery or not less than 96 hours following a cesarean section. Notification to Care Coordination℠ is ONLY required if your stay will be longer than 48 hours following a normal delivery or longer than 96 hours following a cesarean section. If Care Coordination℠ is not notified within two business days or as soon as reasonably possible, benefits will be reduced by $300. Refer to Section 8, Accessing Care, for more information.

The Plan pays for maternity services as follows:

- Initial visit to the ***physician*** to determine pregnancy status
- Pre-natal and post-natal visits
- Charges related to delivery
- Charges for newborn delivery services, paid as follows:
    - Charges billed for well-baby care are paid under the newborn but at the mother's level of benefit, subject to her ***deductible*** and ***out-of-pocket maximum*** (e.g., if mom has met her ***out-of-pocket maximum***, well-baby charges will be reimbursed as if the newborn's out of pocket maximum was met as well)
    - Charges billed for the newborn under any other nonwell baby ***ICD-9*** code are paid under the newborn and subject to the newborn's ***deductible*** and ***out-of-pocket maximum***

Note: The Plan will pay for covered health services for the newborn for the first 31 calendar days of life under the Plan (if the newborn would be eligible to be a Class I dependent). This is regardless of whether the ***primary covered member*** enrolls the dependent within 31 calendar days for continued coverage under the Plan. If the newborn ***child(ren)*** are not added to your medical coverage within 31 calendar days of their birth, any ***eligible expenses*** incurred after the 31-calendar-day period will not be covered.

The Plan will pay for maternity services for covered members that include the ***primary covered member***, the covered spouse, the covered domestic partner, and covered dependent children.

Licensed birthing centers are covered under the Plan to include charges from the birthing center, ***physician***, midwife, surgeon, assistant surgeon (if ***medically appropriate***), and anesthesia.

Benefits for birthing services rendered in the home will be paid according to the network status of the ***physician*** with whom the licensed nurse midwife is affiliated. If the licensed nurse midwife is not affiliated with a ***physician*** and is not a part of the network, reimbursement will be paid on an out-of-network level. If you are admitted to the ***hospital***, you must notify Care Coordination℠ within two business days or as soon as reasonably possible. Refer to Section 8, Accessing Care, for more information.

Important

*Add your newborn **child(ren)** to your medical coverage WITH THE SANDIA BENEFITS DEPARTMENT within 31 calendar days of the birth to continue coverage beyond the first 31 calendar days.*

Medical Supplies

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

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

Lancets, alcohol swabs, diagnostic testing agents, syringes, novopen and insulin auto-injectors, and allergic emergency kits can be obtained through PharmaCare.

Nutritional Counseling

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

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

Obesity Surgery

> ***Prior notification*** to Care Coordination℠ is required at least five business days before receiving services. If Care Coordination℠ is not notified, benefits will be reduced by $300. Refer to Section 8, Accessing Care, for more information.

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

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

Office Visits

The Plan pays for the following services provided in the ***physician's*** office at the applicable ***copay*** level of benefits in-network and the applicable ***coinsurance*** (after the ***deductible***) out-of-network:

- Consultations
- Second opinions
- Post-operative follow-up
- Services after hours and ***emergency*** office visits (allowed separately)
- Allergy testing
- Office surgery

Note: Any anesthesia done in conjunction with surgery that is performed in a ***physician's*** office (in-network) will be reimbursed down to the ***copay***. For example, if you have a surgical procedure done in a ***physician's*** office (in-network) and the ***physician*** bills for anesthesia in conjunction with that surgery, you will incur a ***copay*** for the surgery and a ***copay*** for the anesthesia. Any medical supplies used in conjunction with the surgery performed in a ***physician's*** office (in-network) will be reimbursed at 100 percent of ***eligible expenses***.

The Plan pays for the following services provided in the ***physician's*** office at the applicable ***coinsurance*** level, after the ***deductible***:

- Supplies dispensed by the provider
- Diagnostic tests (with the exception of allergy testing – See Allergy Services in this Section)
- Laboratory services
- Radiology services
- Chemotherapy
- Radiation therapy

Organ Transplants

UHC provides Plan members with access to designated United Resource Networks facilities through the Transplant Resource Services Program. It is not mandatory that you receive services through this Program, but if you do you may be eligible for additional benefits. ***Prior notification*** to Care Coordination℠ or the Transplant Resource Services Program is required as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed). If the Transplant Resource Services Program or Care Coordination℠ is not notified, benefits will be reduced by $300. Refer to Section 8, Accessing Care, for more information.

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

- Heart
- Heart/lung
- Lung
- Kidney
- Kidney/pancreas

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

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

Outpatient Surgical Services

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

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

Benefits for the professional fees are described under Professional Fees for Surgical and Medical Services in this Section. Refer to Office Visits for surgeries performed in a ***physician's*** office.

Prescription Drugs (other than those dispensed by PharmaCare)

The Plan will cover enteral nutrition/prescription drugs under ***UHC*** as follows:

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

Note: Medication obtained through a mail order service is not eligible for reimbursement under ***UHC***. It may be eligible for reimbursement under PharmaCare on an out-of-network basis.

Refer to Appendix A, Prescription Drug Program, for information on coverage of prescription drugs not mentioned above.

Preventive Care

The Plan will not cover all care that is preventive in nature but will cover certain services under the preventive care benefit.

Routine/Annual Physical Exams

One routine physical/annual exam is allowed each calendar year, regardless of the date of the previous routine physical/annual exam, and no more frequently than one per calendar year. A member is eligible for an annual routine physical exam even when the member has any type of chronic illness or condition, such as high blood pressure, diabetes, etc. Allowable exams include routine preventive physicals, including annual exams and sports physicals. For the exam to be covered under the preventive benefit, the provider must bill with a routine diagnosis code, otherwise the service will be reimbursed at the applicable level of benefits.

Note: The Plan will reimburse one well-woman exam per calendar year in addition to a routine physical/annual exam.

Important

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

Well-Baby Care (0-2 years)

- Routine physical exam (including height and weight) at 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 18 months, and 24 months
- Hearing exam, as needed
- Thyroid screen, as needed
- Serum lead screen, as needed
- Sickle cell anemia screen, as needed
- Hemoglobin/Hematocrit, between 9 and 12 months
- Phenylketonuria (***PKU***)

Well-Child Care (3-10 years)

- Routine physical exam (including height and weight)
- Hearing exam (as needed)

*Well-Adolescent Care (**1**1-18 years)*

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

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

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

Immunizations/Flu Shot Services

The Plan will pay 100 percent of the ***eligible expenses*** in-network and 70 percent of the ***eligible expenses*** after the ***deductible,*** if done out-of-network for flu shots, pneumococcal vaccines, and immunizations related to personal travel. If you are unable to obtain the type of immunization required at the ***physician's*** office (e.g., malaria pills) in Albuquerque, NM, you can go to Concentra, 3800 Commons NE (505-822-9480), and receive in-network benefits. If you need different types of immunizations for personal travel where at least one of these is not available at a ***physician's*** office, you may obtain all of your immunizations at Concentra. If you are located anywhere else in the United States, contact ***UHC*** customer service at 1-877-835-9855 for assistance.

Note: Immunizations for Sandia-business-related travel must be given at Sandia's onsite clinic; however, if Sandia's onsite clinic informs the employee to obtain immunizations offsite, the member will be reimbursed at 100 percent of the charge, regardless of whether the member obtains the immunizations in- or out-of-network.

Important

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

Laboratory Services

The Plan will pay 100 percent of the ***eligible expense*** in-network and 70 percent of the ***eligible expense,*** after the ***deductible,*** if done out-of-network, for the following laboratory services for members age 19 and older:

- Complete blood count (CBC) with differential, which includes white blood count, red blood count, hemoglobin, hematocrit, platelet, mcv, mchc, rdw. Differential includes neutrophils, lymphocytes, monosite, eosinophil, basophil, absolute neutrophil, absolute lymphocyte, absolute monocyte, absolute eosinophil, absolute basophil, diff type, platelet estimate, red blood cell morphology.
- Complete urinalysis, which includes source, color, appearance, specific gravity, urine PH, protein, urine glucose, urine ketones, urine bilirubin, blood, nitrate, urobilinogen, leukocyte estrase, red blood count, white blood count, squamos epithelial, calcium oxylate.
- Complete metabolic profile, which includes sodium, potassium, chloride, co2, anion, glucose, bun, creatinine, calcium, total protein, albumin, globulin, bilirubin total, alkphos, asp, alt.
- Diabetes screening, which includes a two-hour postprandial blood sugar and HbA1c.
- Thyroid screening, which includes free T4 and TSH.
- Lipid panel, which includes triglycerides, total cholesterol, ***HDL***, and calculated ***LDL*** cholesterol.

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

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

Important

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

Cancer Screening Services

The Plan will pay 100 percent of the ***eligible expense*** in-network and 70 percent of the ***eligible expense*** after the ***deductible,*** if done out-of-network, for the following services:

Service	Allowed Frequency	Allowable Age
Pap Test	Annual	Upon turning 14
Prostrate Antigen Test	Annual	Upon turning 50
Mammogram*	Baseline Annual	Between ages 35-39 Upon turning 40
Fecal Occult Blood Test	Annual	Upon turning 50
Sigmoidoscopy**	Once every five years	Upon turning 50
Colonoscopy**	Once every ten years	Upon turning 50
Barium Enema**	Once every five years	Upon turning 50

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

** You are entitled to the following:

- A sigmoidoscopy once every five years, OR
- A colonoscopy once every 10 years, OR
- A sigmoidoscopy or colonoscopy under age 50 or more frequently if you have an immediate family history (mother, father, sister, brother only) of colorectal cancer

** A barium enema once every five years in lieu of a colonoscopy or sigmoidoscopy

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

Important

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

Pregnancy-Related Preventive Care Services

The Plan will pay 100 percent of the ***eligible expense*** in-network and 70 percent of the ***eligible expense*** after the ***deductible***, if done out-of-network, for the following pregnancy-related services, on an as needed basis:

- Multiple marker screening between weeks 15 and 18 for pregnant women age 35 and older
- Serum alpha-fetoprotein between weeks 16 and 18 based on personal risk factors
- Chorionic villus sampling before week 13 or amniocentesis between weeks 15 and 18 in women who are 35 and older and at risk for passing on certain chromosomal disorders
- Hemoglobiopathy screening if at risk for passing on certain blood disorders
- Screening for gestational diabetes between 24 and 28 weeks
- Screening for group B strep between 35 and 37 weeks
- Initial screening for anemia, rubella, hepatitis B, and sexually transmitted diseases

Important

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

Bone Density Testing

The Plan will pay 100 percent of the ***eligible expense*** in-network and 70 percent of the ***eligible expense*** after the ***deductible,*** if done out-of-network, for bone density testing once every three years upon turning age 50.

Important

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

Prosthetic Devices/Appliances

The Plan covers prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include:

- Artificial limbs
- Artificial eyes
- Breast prosthesis following a mastectomy, as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras (see Durable Medical Equipment) and lymphedema stockings. Refer to Reconstructive Procedures, this section, for more information. There are no limitations on the number of prosthesis and no time limitations from the date of the mastectomy. Refer to Reconstructive Procedures for more information.

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

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

Professional Fees for Surgical and Medical Procedures

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

The Plan will pay the following surgical expenses:

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

Reconstructive Procedures

Prior notification to Care Coordination℠ is required at least five business days before undergoing a ***reconstructive procedure***. If Care Coordination℠ is not notified, benefits are reduced by $300. Refer to Section 8, Accessing Care, for more information.

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

Important

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

Improving or restoring physiology function means that the organ or body part is made to work better. An example of a ***reconstructive procedure*** is surgery on the inside of the nose so that a person's breathing can be improved or restored. There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Upper eyelid surgery, for example, is sometimes performed to improve vision, which is considered a ***reconstructive procedure***, but in other cases, improvement in appearance is the primary intended purpose, which is considered a ***cosmetic procedure***. ***Cosmetic procedures*** are not covered under this Plan. Refer to Section 7, Exclusions, for more information.

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

Rehabilitation Services (Outpatient Therapies)

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

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

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

Note: Speech, physical, and occupational therapies rendered for developmental disorders are covered until the patient is at a maintenance level of care as determined by ***UHC***.

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

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Prior notification to Care Coordination℠ is required as follows:

- For nonemergency admissions: at least five business days before admission
- For ***emergency*** admissions: within two business days, or as soon as is reasonably possible

If Care Coordination℠ is not notified, benefits will be reduced by $300. Refer to Section 8, Accessing Care, for more information.

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

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

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

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

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

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

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

Temporomandibular Joint (TMJ) Syndrome

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

Urgent Care

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

- If you receive care in an in-network ***urgent care facility*** within the United States, you will be reimbursed under the in-network level of benefits.
- If you receive care in an out-of-network ***urgent care facility*** within the United States, you will be reimbursed under the out-of-network level of benefits.

> **Note:** If you are traveling within the United States and there are no in-network facilities available within a 30-mile radius, your claim will be processed at the in-network benefit level

- If you are traveling outside the United States, your claim will be processed at the applicable in-network benefit level.
- Follow-up care while traveling outside the United States will be covered at the applicable in-network level of benefit.
- Follow-up care while traveling within the United States will be covered at the applicable in-network level of benefits only if the place of care is not located within 30 miles of any in-network provider.

Section 7. Exclusions

Although the ***UHC*** Standard ***PPO*** Plan provides benefits for a wide range of covered health services, there are specific conditions or circumstances for which the Plan will not provide benefit payments. In general, the Plan will not pay for any expense that is primarily for the member's convenience or comfort, or that of the member's family, caretaker, ***physician***, or other medical provider. For exclusions under the Prescription Drug Program, refer to Appendix A, Prescription Drug Program.

General Medical Plan Exclusions

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

Exclusions	Examples
Administrative fees, penalties, and limits	• Charges that exceed what the claims administrator determines are eligible expenses • Insurance filing fees, attorney fees, physician charges for information released to claims administrator, and other service charges and finance or interest charges • Amount you pay as a result of failure to contact UHC for prior notification or pre-certification, including unauthorized care • Employee Assistance Program services when you do not obtain precertification from UBH • Charges incurred for services rendered that are not within the scope of a provider's licensure • Charges for missed appointments
Behavioral Health Services	• Family therapy, including marriage counseling and bereavement counseling. Family therapy, marriage counseling, and bereavement counseling, are covered for employees and their dependents only through the EAP. • Conduct disturbances unless related to a coexisting condition or diagnosis otherwise covered • Educational, vocational, and/or recreational services as outpatient procedures • Biofeedback for treatment of diagnosed medical conditions (see medical benefit for biofeedback) • Treatment for learning disabilities and pervasive developmental disorders (including autism) other than diagnostic evaluation • Treatment for insomnia, other sleep disorders, dementia, neurological disorders, and other disorders with a known physical basis (certain treatments may be covered under medical portion of the Plan)

Exclusions	Examples
	• Treatment that is determined by UBH to be for the member's personal growth or enrichment • Court-ordered placements when such orders are inconsistent with the recommendations for treatment of UBH participating provider for mental health or UBH • Services to treat conditions that are identified by the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders* as not being attributable to a mental disorder • Sex transformations • Any services or supplies that are not medically appropriate • Custodial care • Developmental care • Treatment for caffeine or tobacco addictions (with the exception of hypnotherapy and biofeedback for tobacco addiction), withdrawal, or dependence • Aversion therapies • Treatment for codependency • Nonabstinence-based or nutritionally based treatment for substance abuse • Services, supplies, or treatments that are covered for benefits under the medical part of this Plan • Treatment or consultations provided via telephone, except if used for transition of care or interim care for a maximum of six months • Services, treatments, or supplies provided as a result of any Worker's Compensation law or similar legislation, or obtained through, or required by, any government agency or program, whether federal, state, or any subdivision thereof, or caused by the conduct or omission of a third party for which the member has a claim for damages or relief, unless the member provides UBH with a lien against such claim for damages or relief in a form and manner satisfactory to UBH • Nonorganic erectile dysfunction (psychosexual dysfunction) • Treatment for conduct and impulse control disorders, personality disorders, paraphilias (unusual sexual urges), and other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by UBH • Services or supplies that – are considered experimental or investigational drugs, devices, treatments, or procedures – result from or relate to the application of such experimental or investigational drugs, devices, treatments, or procedures

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

Exclusions	Examples
	– foam cushions – pajamas • Items payable under the prescription drug program (see Appendix A) • Equipment rental fees above the purchase price, with the exception of oxygen equipment
Experimental or investigative treatment	Experimental or investigative drugs, devices, medical treatments, or procedures, and any related services
Hospital fees	• Expenses incurred in any federal hospital, unless the covered member is legally obligated to pay • Hospital room and board charges in excess of the semi-private room rate unless medically appropriate and approved by UHC/UBH • In-hospital personal charges (e.g., telephone, barber, TV service, toothbrushes, slippers)
Hypnotherapy	• Hypnotherapy is generally not a covered health service, but the Plan will allow up to five visits per lifetime for smoking cessation
Infertility, Reproductive, and Family Planning	• Purchase of eggs • Services related to or provided to anonymous donors • Services provided by a doula (labor aide) • Storing and preserving sperm • Donor expenses related to donating eggs/sperm (including prescription drugs) except that charges to extract the eggs from a covered employee for a donor are allowed • Expenses incurred by surrogate mothers • Sex change operations • Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes • Over-the-counter medications for birth control/prevention • Parenting, prenatal, or birthing classes
Miscellaneous	• Eye exams except as outlined under Section 6, Coverages/Limitations • Eyeglasses or contact lenses prescribed, **except** as outlined under Section 6, Coverages/Limitations. Contact lenses are not considered a prosthetic device • Modifications to vehicles and houses for wheelchair access • Health club memberships and programs or spa treatments • Treatment or services – incurred when the patient was not covered under this Plan even if the medical condition being treated began before the date your coverage under the Plan ends

Exclusions	Examples
	– for sickness or injury resulting from the covered member's intentional acts of aggression, including armed aggression, except for injuries inflicted on an innocent bystander (e.g., you did not start the act of aggression) – for job-incurred injury or sickness for which payments are payable under any Workers' Compensation Act, Occupational Disease Law, or similar law – while on active military duty – that are reimbursable through any public program other than Medicare or through no-fault automobile insurance • Charges in connection with surgical procedures for sex changes • Charges for blood or blood plasma that is replaced by or for the patient • Conditions resulting from insurrection, except for injuries inflicted on an innocent bystander who is a covered member under this Plan • Christian Science practitioners and facilities • Food of any kind unless it is the only source of nutrition, there is a diagnosis of dysphagia (difficulty swallowing) or in cases of PKU or RH factor • Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk • Foods to control weight, treat obesity (including liquid diets), lower cholesterol, or control diabetes • Oral vitamins and minerals (with the exception of oral calcium supplements for clinically documented hypoparathyroidism, Niferex, and certain prescription vitamins) as outlined in Appendix A, Prescription Drug Program • Herbs and over-the-counter medications except as specifically allowed under the Plan • Charges prohibited by federal anti-kickback or self-referral statutes • Chelation therapy, except to treat heavy metal poisoning • Diagnostic tests that are: – Delivered in other than a physician's office or health care facility – Self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests • Domiciliary care • Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for ten seconds or longer). Appliances for snoring are always excluded. • Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

Exclusions	Examples
	– Required solely for purposes of career, education, camp, employment, insurance, marriage, or adoption; or as a result of incarceration – Conducted for purposes of medical research – Related to judicial or administrative proceedings or orders – Required to obtain or maintain a license of any type • Private duty nursing received on an inpatient basis • Respite care • Rest cures • Storage of blood, umbilical cord, or other material for use in a covered health service, except if needed for an imminent surgery
Not a covered health service and/or not medically appropriate	Treatments or services determined not to be medically appropriate and a covered health service by UHC or UBH (see medically appropriate service in Appendix C, UHC Premier PPO Acronyms/Definitions)
Old claims	Claims received 12 months after date when charges were incurred.
Physical appearance	• Breast reduction/augmentation except after breast cancer and/or if medically appropriate • Any loss, expense, or charge that results from cosmetic or reconstructive surgery, except after breast cancer. Exceptions to this exclusion include: – repair of defects that result from surgery for which the member was paid benefits under the policy – reconstructive (not cosmetic) repair of a congenital defect that materially corrects a bodily malfunction. **Note:** For the purposes of this exclusion, poor self-image or emotional or psychological distress does not constitute a bodily malfunction. • Liposuction • Pharmacological regimens • Nutritional procedures or treatments • Tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures) • Replacement of an existing intact breast implant unless there is documented evidence of silicon leakage • Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation • Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity • Wigs regardless of the reason for hair loss • Treatments for hair loss

Exclusions	Examples
Providers	Services: • Performed by a provider who is a family member by birth or marriage, including your spouse, brother, sister, parent, or child • A provider may perform on himself or herself • Performed by a provider with your same legal residence • Provided at a diagnostic facility (hospital or otherwise) without a written order from a provider • Ordered by a provider affiliated with a diagnostic facility (hospital or otherwise) when that provider is not actively involved in your medical care – Prior to ordering the service or – After the service is received – This exclusion does not apply to mammography testing.
Services, supplies, therapy, or treatments	Charges that are: • Custodial in nature • Otherwise free of charge to the member • Furnished under an alternative medical plan provided by Sandia • For aromatherapy or rolfing (holistic tissue massage) • For developmental care after a maintenance level of care has been reached • For maintenance care • For massage therapy unless performed by a licensed chiropractor, physical therapist, or physician as a manual therapy technique for lymphatic drainage • For educational therapy when not medically appropriate • For educational testing • For smoking-cessation programs, except for biofeedback and hypnotherapy, which are limited to a maximum of five visits each per lifetime • For surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia, and astigmatism, including but not limited to procedures such as laser and other refractive eye surgery and radial keratotomy
Surgical and nonsurgical treatment for obesity	• Surgical operations for the correction of morbid obesity determined by UHC not to be medically appropriate to preserve the life or health of the member • Over-the-counter appetite control treatment, or treatment for food addictions or for eating disorders that are not documented cases of bulimia or anorexia meeting standard diagnostic criteria as determined by UHC/UBH

Exclusions	Examples
Transplants	• Organ and tissue transplants, including multiple transplants: – Except as identified under Organ Transplants, Section 6, Coverages/Limitations – Determined by Care Coordination not to be proven procedures for the involved diagnoses – Not consistent with the diagnosis of the condition • Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available) • Donor costs for organ or tissue transplantation to another person unless the recipient is a covered member under this Plan
Transportation	• Nonemergency ambulance services are not covered. • Transportation, except ground ambulance and air ambulance services as outlined in Section 6, Coverages/Limitations
Travel	• Travel or transportation expenses, even if ordered by a physician, except as identified under Travel and Lodging in Section 8, Accessing Care

Section 8. Accessing Care

In this section, you will find out about accessing care under the in-network and out-of-network options, ***prior notification*** and ***precertification*** requirements, predetermination of benefits, and accessing nonemergency or nonurgent care while away from home. This section also describes the Behavioral Health Program, the Employee Assistance Program (***EAP***), the United Healthcare (***UHC***) and United Behavioral Health (***UBH***) provider networks, and other general information.

In-Network and Out-of-Network Options

The in-network option provides you access to ***physicians***, facilities, and suppliers who are contracted with ***UHC*** and ***UBH*** to provide their services at negotiated fees. This results in lower out-of-pocket costs to you. When you use the in-network option of the ***UHC*** Standard ***PPO***, all services and supplies covered must be acquired from in-network providers or suppliers and qualify as covered health services under this Plan (see Section 5, Deductibles and Maximums, and Section 6, Coverages/Limitations, for coverage details). No referrals are required. Some procedures may require ***prior notification*** or ***precertification***, which you are responsible for asking your ***physician*** to obtain from ***UHC*** or ***UBH*** (refer to Prior Notification Requirements for Medical Services to Care Coordination℠ and Pre-Certification Requirements for Behavioral Health and Employee Assistance Program Services in this section). For the most updated in-network provider listings, contact ***UHC*** Customer Service at 1-877-835-9855 or online at www.myuhc.com.

The advantages of using the in-network option include:

- ***Copays*** for office visits
- Lower ***deductibles***
- Lower ***out-of-pocket maximums***
- No responsibility for amounts exceeding ***eligible expenses***
- Generally, no claims to file

The out-of-network option offers a lower level of benefit but enables the member to get services from licensed providers outside the Plan network. No referrals are required. The member is responsible for ***deductibles***, ***coinsurance***, and amounts exceeding ***eligible expenses***. The member is also responsible for filing all claims not filed by the provider and must obtain ***prior notification*** or ***precertification*** for all ***hospital*** care and certain medical and ***behavioral health*** care in order to be eligible for full benefits. Refer to Section 5, Deductibles and Maximums, and Section 6, Coverages/Limitations.

Important

You can access either option at any time during the year any time you need medical care.

Prior Notification Requirements for Medical Services to Care Coordination℠

When you choose to receive certain covered health services (listed below), you are responsible for notifying Care Coordination℠ before you receive these services, otherwise your benefits will be reduced. Care Coordination℠ ensures you and/or your covered dependents receive the most appropriate and ***cost effective*** services available.

Important

*Just because a service or procedure does not require **prior notification** or **precertification** does not mean that it is a covered benefit. In order to ensure that services and procedures are covered, you are encouraged to obtain a predetermination of benefits as described in this section.*

You or your provider must notify Care Coordination℠ for:

- nonemergency admissions: at least five business days before admission
- ***emergency*** admissions: within two business days, or as soon as reasonably possible
- other than admissions: at least five business days before receipt of services or purchase or rental of durable medical equipment

The first $300 of covered charges will not be reimbursed if you, a family member, or your provider does not contact Care Coordination℠ within the applicable time frames for the services listed above. An exception to this requirement would be for a covered member who has primary health care coverage for these services under ***Medicare*** or another nonSandia health care plan.

Important

*Most of the time the provider will obtain **prior notification**; however, it is ultimately your responsibility to call **UHC** at 1-877-835-9855 to initiate the review process, whether you or your covered dependent is using in- or out-of-network facilities.*

Services (whether in- or out-of-network) that require Care Coordination℠ notification:

- Congenital Heart Disease services
- Dental services stemming from a ***sickness*** or ***injury***

- ***DME*** for items with a purchase or cumulative rental value of $1,000 or more
- Home health care
- ***Hospice*** care
- ***Hospital inpatient stay***, including ***emergency*** admission
- Maternity care that exceeds the delivery time frames as described in Section 6, Coverages/Limitations

> **Note:** If delivery is at home but requires admission to the ***hospital,*** notification is required.

- ***Reconstructive procedures***
- Air ambulance services
- ***Skilled nursing facility***/inpatient rehabilitation facility services
- Transplantation services

You are encouraged to notify Care Coordination℠ prior to receiving the following services in order for Care Coordination℠ to determine if they are covered health services:

- Breast reduction and reconstruction (except following cancer surgery)
- Vein stripping, ligation, VNUS® Closure, and sclerotherapy (an injection of a chemical to treat varicose veins)
- Blepharoplasty (surgery to correct aging of the eyelids)

These services will not be covered when considered to be ***cosmetic procedures***.

Precertification Requirements for Behavioral Health and Employee Assistance Program (EAP) Services

To find out about ***precertification*** requirements for ***behavioral health*** services or ***EAP*** services, see Behavioral Health Program and/or ***EAP*** in this section.

Important

*Just because a service or procedure does not require **prior notification** or **precertification** does not mean that it is a covered benefit. In order to ensure that services and procedures are covered, you are encouraged to obtain a predetermination of benefits as described in this section.*

Predetermination of Benefits

The ***UHC*** Standard ***PPO*** covers a wide range of medical care treatments and procedures. However, medical treatments that are ***investigational***, ***experimental***, or ***unproven*** to be

medically effective are not covered by this Plan. Contact ***UHC*** or ***UBH*** before incurring charges that may not be covered.

In addition, some services may be covered only under certain circumstances and/or and may be limited in scope, including but not limited to speech therapy, occupational therapy, ***TMJ*** syndrome, infertility, procedures that may have a cosmetic effect, and physical therapy. Predetermination of benefits is recommended to help you determine your out-of-pocket expense. Also, some benefits require ***prior notification*** or ***precertification***; therefore, it is important that you call ***UHC*** or ***UBH*** for information on covered services. If you have any questions about how to obtain a predetermination of benefits, contact ***UHC*** Customer Service at 1-877-835-9855.

Nonemergency or Nonurgent Care Away from Home

UHC and ***UBH*** have contracted with providers in more than 370 metropolitan areas. If you are not experiencing an ***emergency*** or urgent situation, call ***UHC*** or ***UBH*** at 1-877-835-9855 to obtain information on in-network providers in the area or what to do if there are no in-network providers within a 30-mile radius of your location.

Behavioral Health Program

Your Behavioral Health Program and the network of ***behavioral health*** care ***specialists*** are managed by United Behavioral Health (***UBH***), the company within ***UHC*** that handles the mental health and ***substance abuse*** programs. The Plan provides for both in-network and out-of-network benefits. You may select providers either in-network or out-of-network; however, using your in-network benefit allows you to receive the maximum available benefit.

Important

*Just because a service or procedure does not require **prior notification** or **precertification** does not mean it is covered. In order to ensure that services and procedures are covered, you are encouraged to obtain a predetermination of benefits as described in this Section.*

You or your provider must precertify with ***UBH*** for:

- nonemergency admissions: at least five business days before admission
- ***emergency*** admissions: within two business days, or as soon as reasonably possible
- other than admissions: at least five business days before receipt of services

The first $300 of covered charges will not be reimbursed if you, a family member, or your provider does not contact ***UBH*** within the applicable time frames for the services listed above. An exception to this requirement would be for a covered member who has primary health care coverage for these services under ***Medicare*** or another nonSandia health care plan.

Precertification is required for the following ***behavioral health*** services from in- or out-of-network providers:

- Neuropsychological testing
- ***Intensive outpatient stays/program***
- Inpatient hospitalization
- ***Partial hospitalization***
- Residential treatment stays/programs

Important

*Most of the time the in-network facility will obtain **precertification**; however, it is ultimately your responsibility to call **UHC** at 1-877-835-9855 (select Care Coordination℠) to initiate the review process whether you or your covered dependent are using in- or out-of-network facilities.*

The following chart summarizes the benefits and limitations. (Refer to Section 6, Coverages/Limitations for more information.)

UBH – Behavioral Health Program	
In-Network Option	**Out-of-Network Option**
• Precertification required from UBH for inpatient, residential, partial hospitalization, neuropsychological testing, or intensive outpatient stays/programs	• Precertification from UBH for inpatient, residential, partial hospitalization, neuropsychological testing, or intensive outpatient stays/programs
• Out-of-pocket maximum applicable	• Out-of-pocket maximum not applicable
• Must use UBH network provider or facility	• Use of non-UBH network provider or facility
• Plan pays 80 percent of eligible expenses (after the deductible) for inpatient and outpatient services	• Plan pays 50 percent of eligible expenses (after deductible) for inpatient and outpatient services
• Annual visit maximum – 20 visits in-network and out-of-network combined per calendar year	• Annual visit maximum – 20 visits in-network and out-of-network combined per calendar year
• Inpatient day limits – 60 days in-network and out-of-network combined per calendar year	• Inpatient day limits – 60 days in-network and out-of-network combined per calendar year

In-Network Option

Access inpatient and/or ***outpatient behavioral health*** care services through self-selection of a contracted ***behavioral health*** care ***specialist*** or ***hospital*** by calling ***UHC*** Customer Service at 1-877-835-9855 to verify that the provider you have chosen is in the network. You can also view in-network providers by registering on www.myuhc.com and selecting Physicians & Facilities.

Out-of-Network Option

Accessing out-of-network services means that you have selected a ***behavioral health*** care ***specialist*** or ***hospital*** outside the ***UBH*** provider network. Selecting an out-of-network ***specialist*** or ***hospital*** reduces your available benefit as outlined in the table above.

If a member is admitted to a ***hospital*** on an ***emergency*** basis that is not in the network and services are covered, in-network benefits will be paid until the patient is stabilized. Once stabilized, the patient must be moved to a network ***hospital*** to continue in-network benefits. The patient may elect to remain in the out-of-network ***hospital*** and receive out-of-network benefits, as long as ***UBH*** confirms the treatment to be ***medically appropriate***.

Employee Assistance Program (EAP)

Sandia offers employees and their covered dependents the counseling services of an Employee Assistance Program (***EAP***): onsite and offsite. ***EAP*** services are designed to provide assessment, referral, and follow-up to employees experiencing some impairment from personal concerns including, but not limited to, health, marital, family, financial, ***substance abuse***, legal, emotional, stress, or other personal concerns that may adversely affect their day-to-day activities.

Onsite EAP Services

Obtain onsite ***EAP*** counseling by contacting your Sandia ***EAP*** office. The Sandia ***EAP*** is administered by Sandia Medical Services and is not part of the ***UHC*** Standard ***PPO*** Plan. The Sandia ***EAP*** provides information regarding education and training programs at the worksite that focus on mental health issues such as ***substance abuse***, family and marital concerns, stress, and healthy lifestyle development. The Sandia ***EAP*** also assists employees and managers in resolving work-related issues that might affect job productivity.

For further information, call:

New Mexico: (505) 845-8085
California: (925) 294-2200

Offsite EAP Benefits

Your ***EAP*** benefit allows up to eight visits a year to offsite in-network ***EAP*** providers at no cost to you. Obtain a referral to an offsite ***EAP counselor*** through the Plan by contacting LifeEra (a division of ***UHC***) at 1-866-828-6049, 24 hours a day, seven days a week.

You also have access to an interactive website that provides electronic access and delivery of your ***EAP*** benefit, as well as resources and tools to help you enhance your work, health, and life. You can access this website either by registering on www.myuhc.com and selecting Physicians & Facilities, or by going to www.liveandworkwell.com (without registering) and input SNL as the access code. This website allows you to:

- Check your ***EAP*** benefits information and request services online
- Look up health facts and read articles on Life Events issues
- Use a host of financial calculators and other interactive tools
- Join interactive discussions, chats, and message boards on a variety of health and wellness topics
- Take quizzes and participate in customized self-improvement programs

Precertification Requirements for Offsite EAP Services

Contact LifeEra at 1-866-828-6049 to receive ***precertification*** for offsite ***EAP*** services. If ***precertification*** is not obtained, no reimbursement will be allowed.

Confidentiality

EAP counseling services are confidential within the limitations imposed by state and federal law and regulations. When a member visits an ***EAP counselor*** for the first time, confidentiality is described in more detail.

Provider Networks

Network availability depends on the ability of the administrator to contract with provider networks. ***UHC*** and ***UBH*** have contracted with networks across the country. You may access in-network ***PPO*** providers in most areas nationwide.

The networks and/or network providers are contracted by ***UHC*** and ***UBH***. ***UHC/UBH*** is responsible for maintaining these provider networks. Neither Sandia nor ***UHC/UBH*** can guarantee quality of care. Employees always have the choice of what services they receive and who provides their health care regardless of what the plan covers or pays.

In the greater Albuquerque area, providers, specialty care ***physicians***, ***hospitals***, and other health care providers/facilities participating in the ***UHC*** network are affiliated with Pres-

byterian and University of New Mexico hospitals. In some cases, ***UHC*** has direct contracts with other providers. The ***participating providers*** work with ***UHC*** and ***UBH*** to organize an effective and efficient health care delivery system. Outside the greater Albuquerque area, ***UHC*** and ***UBH*** contract with providers offering in-network care.

In Northern California, providers, specialty care ***physicians***, ***hospitals***, and other health care providers/facilities participating in the ***UHC*** network are affiliated with multiple facilities.

In other areas, ***UHC*** and ***UBH*** contract with provider networks all over the United States.

Note: If your provider is interested in becoming an in-network provider, he/she can call ***UHC*** Customer Service to inquire about the process. There is also a provider nomination form located on the www.myuhc.com website (user ***ID*** and password of SNL).

United Resource Networks (URN) Programs

UHC offers designated ***URN*** programs for congestive heart disease, reproductive services, cancer services, and organ transplants for members in the ***UHC*** Standard ***PPO*** Plan. Individuals with complex, unusual, or rare medical conditions have a likelihood of better outcomes when they are diagnosed and treated by medical professionals with precise clinical expertise. The ***URN*** programs were developed to support safe, successful, and ***cost effective*** support of individuals with these conditions. These programs are optional and are not required in order to receive benefits. However, your costs may be lower due to the fact that these networks typically have better negotiated rates with ***UHC***. In addition, you may have access to additional facilities on an in-network basis through these programs. Finally, for transplants, cancer and congenital heart disease services, you may be eligible for a travel and lodging benefit through these programs as described below. To access information on these programs, call 1-877-835-9855.

URN will assist the patient and family with travel and lodging arrangements related to:

- Congenital heart disease
- Transplantation services
- Cancer-related treatments

Important

*For travel and lodging services to be covered, the patient must be receiving services at a designated **URN** facility through the Transplant Resource Services Program, the Congenital Heart Disease Resource Services Program, or the Cancer Resource Services Program, as described on the following pages.*

The Plan covers expenses for travel, lodging, and meals for the patient and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day to and/or from the site of the cancer-related treatment, the congenital heart disease service, or the transplant for the purposes of an evaluation, the procedure, or necessary post-discharge follow-up
- ***Eligible expenses*** for lodging and meals for the patient (while not a ***hospital*** inpatient) and one companion. Benefits are paid at a rate of up to $50 per day for the patient or up to $100 per day for the patient plus one companion
- If the patient is an enrolled dependent minor ***child*** (i.e., under the age of 18), the transportation expenses of two companions will be covered, and lodging and meal expenses will be reimbursed at a rate of up to $100 per day.

Travel and lodging expenses are only available if the recipient lives more than 50 miles from the designated ***URN*** facility that is being accessed through the Transplant Resource Services Program, the Congenital Heart Disease (CHD) Resource Services Program, or the Cancer Resource Services Program. ***UHC*** must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

- Airfare at coach rate
- Taxi or ground transportation and/or
- Mileage reimbursement at the IRS rate for the most direct route between the patient's home and designated ***URN*** facility

A combined overall maximum benefit of $10,000 per covered patient applies for all travel, lodging, and meal expenses reimbursed under this Plan in connection with all cancer treatments and transplant procedures and CHD treatments during the entire period that person is covered under this Plan.

Transplant Resource Services Program (Organ/Tissue Transplantation)

The Transplant Resource Services Program employs a three-tiered approach to transplant benefit management.

1. The Transplant Resource Services Premium Network – access to clinical and financial excellence in transplantation. Patients benefit from network usage through the opportunity for improved outcomes and significant cost savings associated with transplantation and the wealth of clinical information available on each network ***physician*** and/or health care professional to assist in the patient referral process.

Transplant Resource Services contracts for the following transplant services:

- Blood/marrow
- Heart
- Heart/lung
- Intestinal
- Intestinal/liver
- Kidney
- Kidney/pancreas
- Liver
- Liver/kidney
- Lung
- Pancreas
- Pancreas after kidney

Transplant Resource Services' contracts apply to the entire transplant event, with pre-negotiated rates for transplant-related services performed at the contracted medical center, including:

- Pre-transplant evaluation
- ***Hospital*** and ***physician*** fees
- Organ acquisition and procurement, blood/marrow acquisition and donor search charges
- Transplant procedure
- Up to 12 months of follow-up care for transplant-related services

2. The Transplant Access Program – for geographic access, economic value and administrative relief. The Program provides discounted rates for transplantation at a number of medical centers throughout the United States that are not in the Transplant Resources Premium Network. Participating Program ***physicians*** and other health care professionals do not undergo Transplant Resource Services' rigorous credentialing process; therefore, clinical information regarding these providers is not available to promote referral.
3. Extra Contractual Services – for contracting expertise on a case-by-case basis. These services are available on a case-by-case basis for patient referrals that fall outside of The Transplant Resource Services Premium Network or The Transplant Access Program.

For information on transplant coverage, refer to Section 6, Coverages/Limitations.

Cancer Resource Services Program

The Cancer Resource Services Program and associated nurse consulting services help manage rare, complex, and potentially high-cost cancers while providing access to a full range of comprehensive cancer treatment services through the Program's centers of excellence cancer treatment facilities. The benefits of using this Program include:

- Consultation from nurses about options to help you make an informed decision about which cancer care provider is best for you

- In-network coverage for care at cancer centers that have passed rigorous criteria
- Access to information about coverage, scheduling appointments, finding lodging, and other services
- Accurate diagnosis and few complications
- Care that is planned, coordinated, and provided by a team of experts who specializes in the patient's specific cancer
- Appropriate therapy
- Higher survival rates, shorter length of stay, and decreased costs

For information on coverage, refer to Section 6, Coverages/Limitations.

Congenital Heart Disease Resource Services Program

The Congenital Heart Disease (CHD) Resource Services Program complements the heart programs within the Transplant Resource Services Program to help customers manage congenital heart disease cases.

Goals of CHD Resource Services include:

- Access to quality care for individuals with CHD
- Information regarding "best practice" in CHD care
- Awareness among treating ***physicians*** and parents regarding the availability of CHD Resource Services Program
- Identification of individuals with CHD in-utero or at birth which allows time for education and guidance, offering the opportunity for improved outcomes and decreased CHD days, resulting in lower-cost CHD events.

Designated cardiothoracic surgeons are available to discuss clinical issues and potential referrals with referring ***physicians*** and medical directors.

Reproductive Resource Services Program for Infertility

The Reproductive Resource Services Program provides detailed information to help patients determine their best course of action for infertility diagnosis and treatment. In addition, it provides access to a network of more than 50 facilities that specialize in the treatment of infertility, with reimbursement at in-network rates.

The following services are available:

- Straightforward information about the clinical and nonclinical issues surrounding infertility and its treatment, including infertility centers and ***physicians***. Nurses help patients understand their optimal treatment options and assist them with the selection of a specialized network facility or ***physician***.

- Consultation with nurse consultants about options to help patient make an informed decision about which Reproductive Resource Services center is best for them.
- Access to infertility centers of excellence (clinics with high pregnancy rates and reduced risk of multiple births)

For information on infertility coverage, refer to Section 6, Coverages/Limitations.

Shared Savings Program

The Shared Savings Program helps you manage out-of-pocket costs when you seek medical care outside of the ***UHC*** network.

When you seek health care outside the ***UHC*** network, your resulting out-of-pocket costs will generally be higher. However, when you receive health care from ***physicians*** and facilities which are part of the Shared Savings Program:

- Although your claim will still be paid at the out-of-network benefit level, it will be paid at a discounted rate, which will be used to determine the amount of your out-of-pocket cost
- In addition, shared savings ***physicians*** and facilities will not collect the portion of billed charges that exceeds the discounted rate.

Depending on the geographic area and the service you receive, you may have access to nonnetwork providers who participate in the Shared Savings Program and have agreed to discount their charges for covered health services.

To find providers in the Shared Savings Program, you must register on the www.myuhc.com website. Go to Physicians and Facilities and select Shared Savings.

Provider Directories

UHC and ***UBH*** Provider Directories list providers, facilities, and auxiliary services that have contracted to participate in the network. You can select your ***physician*** from family care ***physicians***, internists, pediatricians, and other ***specialists***. Specialty care and ***hospital*** services generally are provided by the ***hospital*** with which the ***physicians*** and ***specialists*** you select are affiliated.

To obtain a hard copy provider directory, at no cost to you, for any network within the United States, contact ***UHC*** Customer Service at 1-877-835-9855. Directories are current as of the date printed. The provider networks change often. For the most current information, it is recommended that you use the online provider search at www.myuhc.com.

Provider Searches Online

To search for a provider online:

- Log on to www.myuhc.com (you will need to register)
- To find medical providers, select Physicians & Facilities
  - To find a ***physician***, select Find a Physician
  - To find a ***hospital***, select Find a Hospital
- To find ***behavioral health*** providers, select Physicians & Facilities
  - Select Find Mental Health/Substance Abuse Care
  - Click on Go To LiveAndWorkWell

When You Schedule An Appointment

When you call the provider's office to make an appointment, identify yourself as a ***UHC*** Standard ***PPO*** member. When you check in for your appointment, use your ***UHC*** Standard ***PPO*** identification card to identify your plan coverage to facilitate the processing of your claim.

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

Obtain receipts for ***copayments*** at the time of the visit if you are claiming your ***copayments*** against the Sandia ***Health Care Reimbursement Spending Account***.

Canceling Your Appointment – If you cannot keep your appointment, please be courteous to other members and to your providers by calling to cancel your appointment. The time you leave open can be used by someone else. Any charge for missed appointments will not be covered by the Plan.

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

When You Change Your Address

When you move, please change your address in the Sandia database. Active employees may change their address via Sandia's website or their center secretary. Retirees should contact the retirement coordinator through Sandia ***HBES*** at (505) 844-4237. ***COBRA*** and surviving spouse participants should notify the ***COBRA*** coordinator at (505) 844-0358.

If you relocate, your ***PPO*** network could change. For provider information, access www.myuhc.com for the most up-to-date provider information.

If you move to California and wish to enroll in the Kaiser ***HMO***, you must enroll through the Sandia California Benefits Office within 31 calendar days of the move.

NM ***HBES*** (505) 844-4237 or 1-800-417-2634, then 844-4237 (HBES)

CA Benefits (925) 294-2254

UHC Customer Service

UHC Customer Service (see Appendix E for contact information) consists of trained representatives who can help members in the following areas:

- Obtaining identification cards
- Obtaining Plan benefit information
- Inquiring about claims
- Verifying eligibility
- Inquiring about provider networks
- Providing a hardcopy of the provider directory
- Resolving complaints

Identification Cards

If you have elected employee-only coverage, you will receive one ***UHC*** Standard ***PPO ID*** card. If you have elected any other coverage, you will receive two ***UHC*** Standard ***PPO ID*** cards. You may obtain additional ***ID*** cards through www.myuhc.com or by calling ***UHC*** Customer Service at 1-877-835-9855. The ***UHC*** Standard ***PPO ID*** card identifies you to providers as an eligible Plan member. The card contains:

- Your name and the names of any covered dependents
- A unique subscriber ***ID*** number that has been assigned to you by ***UHC*** and is linked to the primary subscriber's Social Security number in ***UHC's*** system
- The group contract number you are enrolled in
- The claims filing address
- The Customer Service phone number
- An authorized signature box

Note: Either you or any of your covered dependents can sign the card.

Important

*Always present your **UHC** Standard **PPO ID** card when obtaining health care.*

Section 9. Resources for Healthy Living

In this section, you will learn about the various resources ***UHC*** has to help you stay healthy as well as become an educated consumer, such as the Optum NurseLine, the ***UHC*** FOCUS Program (which includes case management and disease management services), the Healthy Pregnancy Program, the UnitedHealth Allies Health Discount Program, and resources available on the www.myuhc.com website.

Optum NurseLine

Questions about health can come up at any time, which is why it is important to have easy access to a trusted source of information and support 24 hours every day. With Optum NurseLine, you have such a source – available through telephone conversations, the Internet, or informational recorded messages.

Telephone

NurseLine provides you with a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week, for routine or urgent health concerns. Call 1-800-563-0416 to learn more about:

- A recent diagnosis
- A minor ***sickness*** or ***injury***
- Men's, women's, and children's wellness
- How to take prescription drugs safely
- What questions to ask your doctor before a visit
- For help understanding your test results
- Information that can help you decide when the ***emergency*** room, ***urgent care***, a doctor visit, or self-care is appropriate

Important

*If you have a **medical emergency**, call 911, not Optum NurseLine.*

- Self-care tips and treatment options
- Healthy living habits
- Any other health related topic

Informational Recorded Messages

NurseLine gives you another convenient way to access health information through informational recorded messages. Call 1-800-563-0416 to listen to one of the Health Informa-

tion Library's over 1,100 recorded messages. There are also 590 messages available in Spanish.

Live Nurse Chat

With NurseLine, you also have access to nurses online. To use this service, log onto www.myuhc.com and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

UnitedHealth FOCUS Program

UnitedHealthcare offers members who are living with a chronic condition or dealing with complex health care needs the UnitedHealth FOCUS Program. The goal of this program is to provide a high level of support and help you become as informed as possible.

With FOCUS, you have phone access to a registered nurse who is assigned to you and your family and who can tell you more about the benefits available to you and offer information about a wide range of health issues. This Program is at no additional cost to you.

FOCUS matches you with the ***UHC*** case and/or disease management programs that may work for you. It also provides access to resources that can give you confidence when making health care decisions and provides you the right tools for making the most out of every conversation with your doctor. Your recent prescriptions (provided by PharmaCare directly to UnitedHealthcare), doctors visits, or ***hospital*** stays can indicate to ***UHC*** when their programs may help. Or you might complete a Health Risk Assessment, which gives ***UHC*** information that they may be able to use to assist you with an illness or chronic condition. If it appears to ***UHC*** that you and/or your dependents might benefit from this program, you will be contacted by a registered nurse to discuss whether this voluntary program is of interest to you.

If you have questions about or feel you may benefit from this program, call 1-877-835-9855.

Case Management Program

If you are living with a chronic condition or dealing with complex health care needs, upon notification to Care Coordination℠, ***UHC*** may assign to you a primary nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. Your pri-

mary nurse will provide you with a direct telephone number so you can contact them about your conditions, or your overall health and well-being.

UHC nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. The Case Management Program includes:

Admission Counseling – For upcoming inpatient ***hospital*** admissions for certain conditions, a ***UHC*** primary nurse may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery.

Inpatient Care Advocacy – If you are hospitalized, your primary nurse will work with your ***physician*** to ensure you are getting the care you need and that your ***physician's*** treatment plan is being carried out effectively.

Readmission Management – This program serves as a bridge between the ***hospital*** and your home if you are at high risk of being readmitted. After leaving the ***hospital***, if you have a certain chronic or complex condition, you may receive a phone call from a ***UHC*** nurse to confirm that medications, needed equipment, or follow-up services are in place. The nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.

Additional benefits of having a primary nurse include:

- Individualized information to help you find ways to improve your health
- A plan to help you learn about preventive care and treatment options
- Proactive outreach to your ***physicians*** and ***specialists***
- Answering questions about certain procedures, treatment options, and
- Working with your doctor during a ***hospital*** stay to reduce delays on tests and procedures.

If you do not receive a call from a ***UHC*** nurse, but feel you could benefit from case management services, call 1-877-835-9855.

Disease Management Program

When you are enrolled in the Disease Management Program, you have phone access to a registered nurse who is assigned to you and your family members and will be your main point of contact. You will be provided with a direct phone number to your nurse.

If you and/or your covered dependents are living with a chronic condition such as coronary artery disease, diabetes, heart failure, or asthma, the Disease Management Program provides voluntary disease management services to include:

- Assignment of a ***UHC*** nurse
- Mailing of information about your condition to your home

UHC uses a variety of internal sources, such as claims, calls to Care Coordination℠, health risk assessments, etc., to identify potential candidates for disease management services. Therefore, you may receive an outreach call from a nurse to ask if you would like to join this program. This program is voluntary; if you do not wish to participate at the time you receive a call, you can inform the nurse of your election. If you are interested in this program, call 1-877-835-9855 to learn more.

Sandia Onsite Disease Management Clinic

Sandia also provides employees located in Albuquerque, NM, with onsite disease management services. The Disease Management Clinic (DMC) is a worksite specialty clinic designed to provide an exceptional level of health care for diabetes, cholesterol, and blood pressure disorders. With a unified commitment to the best care practices available, the DMC is Sandia's interface to workplace health care and health plan services. The DMC provides access to onsite screenings, health care exams, preventive health education, care management, behavioral, fitness, and nutrition services, periodic laboratory testing, immunizations, and podiatry services for diabetic foot care. Our multidisciplinary team of health professionals consists of internal medicine ***physicians***, certified diabetes educators, dieticians, health educators, and exercise specialists.

If you are a current on-roll employee who is at increased risk for or have a history of elevated blood pressure, cholesterol, or diabetes and you are interested in becoming involved in the DMC, contact (505) 844-HBES (4237) to schedule an appointment.

Healthy Pregnancy Program

The voluntary Healthy Pregnancy Program offers free personal support through all stages of pregnancy and delivery. This Program is offered at no cost to you. To enroll, call 1-800-411-7984 between 8 a.m. and 10 p.m. MST, Monday through Friday. If you or your covered dependents are enrolled in this Program, you can get valuable educational information and advice. You or your covered dependent are encouraged to enroll within the first 12 weeks of pregnancy; however, you can enroll at any time, up to your 34th week.

When you call to enroll, a maternity nurse will fill out a pregnancy assessment with you over the telephone. The maternity nurse will review your completed assessment and determine if you have special pregnancy needs. If you or your dependent are identified as a mother-to-be with special health needs, the Program offers additional resources to help you.

This Program offers:

- Maternity nurses on duty 24 hours a day
- A free copy of *The Healthy Pregnancy Guide*
- A phone call from a maternity nurse halfway through the pregnancy to see how things are going
- A phone call from a nurse approximately four weeks postpartum to provide information on topics such as infant care, feeding, nutrition, and immunizations,
- A copy of an available publication, for example, *Healthy Baby Book*, which focuses on the first two years of life

My UHC Website

UHC's member website, www.myuhn.com, offers practical and personalized tools and information so you can get the most out of your benefits. Once you have registered at www.myuhc.com, you can:

- Search for in-network providers
- Learn about health conditions, treatments, and procedures
- Access content and wellness topics from Optum NurseLine, including Live Nurse Chat, 24 hours a day, seven days a week
- Complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques, and access health improvement resources
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area
- Use the hospital comparison tool to compare ***hospitals*** in your area on various patient safety and quality measures
- Make real-time inquiries into the status and history of your claims
- View eligibility and benefit information
- View and print explanation of benefits (***EOB***) online
- Print a temporary ***ID*** card or request a replacement ***ID*** card
- Update dependent ***coordination of benefits*** (***COB***) status
- Organize your health information in one place with the online Personal Health Manager and Personal Health Summary

To register as a www.myuhc.com subscriber, go to www.myuhc.com and click on Register Now. Have your ***UHC ID*** card handy.

UnitedHealth Allies Health Discount Program

Note: The following program is made available solely by ***UHC*** to members in the ***UHC*** Standard ***PPO*** Plan and is not part of the ***UHC*** Standard ***PPO*** Plan itself. Sandia does not sponsor or maintain this program, but has agreed to make members aware of the services. Sandia is not responsible for the design or administration of this program. Contact ***UHC*** at 1-877-835-9855 with any questions or concerns about the program. The provisions of *Your ERISA Rights* (provided in a separate booklet) do not apply to this program. Sandia is including this description here merely for your convenience.

The UnitedHealth Allies Health Discount Program helps you and your covered dependents save up to 50 percent on certain health care services that may not be covered under the ***UHC*** Standard ***PPO*** Plan.

Products and services available under the UnitedHealth Allies Health Discount Program include:

- Laser eye surgery, extra glasses, additional contacts, prescription sunglasses
- Cosmetic dental services such as teeth whitening and veneers
- Massage therapy and natural medicine
- Nutritional counseling, weight management, and smoking cessation
- Hearing tests and devices
- Fitness clubs

With the UnitedHealth Allies Health Discount Program, there are no referrals required, and there are no claim forms to submit.

To locate participating health care professionals:

- Register at www.myuhc.com and click on United Health Allies under My Coverage & Costs
- Log onto www.unitedhealthallies.com
- Call UnitedHealth Allies Customer Care at 1-800-860-8773

Section 10. Claims and Appeals

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

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

Note: For ***coordination of benefits*** information with ***Medicare***, refer to the ***UHC*** Senior Premier ***PPO*** Plan ***SPD***.

Important

*If you are eligible for **Medicare primary** coverage and are covered under this Plan (under the continuation provisions under **COBRA** or as a result of end-stage renal disease), **Medicare** is considered your primary coverage and benefits are coordinated with **Medicare** as though you have both **Medicare** Parts A and B (whether or not you enrolled in Parts A and B). If it is later determined that you became eligible for **Medicare primary** coverage and continued coverage under this Plan, and Sandia paid benefits on a primary basis, the Plan will retroactively coordinate benefits with **Medicare**, and if the Plan is unable to recover reimbursement from **Medicare** or the provider, you will be responsible for reimbursing the Plan. Refer to the **Medicare** booklet Medicare & You for more information. Access the booklet from **Medicare** at www.medicare.gov or 1-800-633-4227, or by contacting your local Social Security office.*

Obtaining Reimbursement

All claims must be submitted within 12 months after the date of service in order to be eligible for consideration of payment. This 12-month requirement will not apply if you are legally incapacitated. If your claim relates to an ***inpatient stay***, the date of service is the date your ***inpatient stay*** ends. We recommend that claims be submitted as soon as possible after the medical expenses are incurred. If you need assistance in filing a claim, call ***UHC*** Customer Service at 1-877-835-9855.

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

To obtain reimbursement for medical care, attach the itemized medical bill to the claim form and mail it to the address shown on the claim form or the address on your ***UHC*** Standard ***PPO ID*** card (see Appendix E for how to obtain claim forms). Itemized medical bills should include:

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

For prescription drugs purchased at out-of-network pharmacies, file your claims following the instructions outlined in Appendix A, Prescription Drug Program.

Note: See Obtaining Claim Forms/Envelopes, Appendix E.

Benefits Payments

UHC and/or ***UBH*** will pay benefits to you unless:

- The provider notifies ***UHC*** and/or ***UBH*** that you have provided signed authorization to assign benefits directly to that provider
- You make a written request for an out-of-network provider to be paid directly at the time you submit your claim

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

If any benefits of the plan shall be payable to the estate of a member or to a minor or individual who is incompetent to give a valid release, the plan may pay such benefits to any relative or other person either whom the plan determines to have accepted competent responsibility for the care of such individual or otherwise required by law. Any payment made by the plan in good faith pursuant to this provision shall fully discharge the plan and the company to the extent of such payment.

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

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

UHC and/or ***UBH*** will send you an ***EOB*** after processing the claim. The ***EOB*** will let you know if there is any portion of the bill you need to pay. If any claims are denied in whole or in part, the ***EOB*** will include the reason for the denial or partial payment. You can also view and print all of your ***EOBs*** online at www.myuhc.com.

Timing of Claims Payments

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

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

Urgent Care Claims

Time Frame for Response from UHC/UBH

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

Extension

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

Period for Claimant to Complete Claim

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

Other Related Notices

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

Nonurgent Pre-service Claims

Time Frame for Response from UHC/UBH

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

Extension

UHC and/or ***UBH*** may extend the original time frame by up to 15 days if necessary due to matters beyond the Plan's control. ***UHC*** and/or ***UBH*** must notify the claimant of the extension before the initial period ends.

Period for Claimant to Complete Claim

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

Nonurgent Post-service Claims

Time Frame for Response from UBH/UHC

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

Extension

UHC and/or ***UBH*** may extend the original time frame by up to 15 days if necessary due to matters beyond the Plan's control. ***UHC*** and/or ***UBH*** must notify the claimant of the extension notice before the initial period ends.

Period for Claimant to Complete Claim

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

and/or ***UBH*** may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Concurrent Care Claims

Time Frame for Response from UHC/UBH

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

Contents of Notice and Response from UHC and/or UBH

The notice will include all of the following:

- Specific reasons for the denial
- Specific references to the Plan provisions upon which the denial is based
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary
- An explanation of the Plan's appeal procedure, its deadlines, including, if applicable, the expedited review available for urgent claims, and the claimant's right to bring a civil action under Section 502(a) of ***ERISA*** following an adverse decision on appeal
- A copy of any rule or guideline relied upon in making the adverse determination, or a statement that the rule or guideline was relied upon (provided, upon request, free of charge)
- If the adverse determination is based on a ***medical appropriateness*** or ***experimental*** treatment or similar exclusion or limit, either an explanation of the specific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Claim Denials and Appeals

Sandia is committed to capturing, as error-free as possible, the information you provide us. ***UHC*** and/or ***UBH*** use this information to review and process your claims as quickly and accurately as possible.

If ***UHC*** and/or ***UBH*** deny your (or a dependent's) claim because of eligibility, refer to Section 2, Eligibility.

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

If you have a claim denied because of . . .	then . . .
coverage eligibility (except for disability determinations)	contact Sandia HBES at (505) 844-HBES (4237)
benefits administration or any other reason	contact UHC at 1-877-835-9855

Filing an Appeal

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

Important

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

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

For urgent claims that have been denied, you or your provider can call ***UHC*** at 1-877-835-9855 to request an appeal.

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

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

Send the written appeal to:

UnitedHealthcare – Appeals
PO Box 30432
Salt Lake City, UT 84130-0432

Two Levels of Appeals

Two levels of appeal are permitted for each type of claim that is denied:

Step 1: First Level of Appeal

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

Step 2: Second Level of Appeal

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

Timing of Appeals Decisions

The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, you should determine whether it is an:

- ***Urgent care*** claim
- Pre-service claim
- Concurrent care claim
- Post-service claim

Separate schedules apply to the timing of claim appeals, depending on the type of claim as referenced earlier. If the claimant does not receive a written response from ***UHC*** and/or ***UBH*** within the time periods described above, the claimant should treat the claim as denied and proceed immediately to the next level of appeal, request an external review, or seek legal recourse.

Important

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

Urgent Care Claims

Period for Filing Appeals

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

Note: You do not need to submit ***urgent care*** claim appeals in writing. You should call ***UHC*** and/or ***UBH*** as soon as possible to appeal an ***urgent care*** claim.

Time Frame for Response from UHC/UBH

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

Nonurgent Pre-service Claims

Period for Filing Appeals

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

Time Frame for Response from UBH/UHC

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

Nonurgent Post-service Claims

Period for Filing Appeals

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

Time Frame for Response from UHC/UBH

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

External Review

If you are not fully satisfied with the decision following completion of the second-level appeal process, and your claim was denied based upon lack of ***medical appropriateness*** or the ***experimental*** nature of the treatment, and if your claim was above $1,000, you may request that your claim be reviewed by an external independent review organization. The independent review organization is composed of people who are not employed by ***UHC*** and/or ***UBH*** or any of its affiliates. There is no charge for you to initiate this independent review process. ***UHC*** and/or ***UBH*** will abide by the decision of the independent review. Administrative eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process. To request a review, you must write to ***UHC*** at the address above within 180 days of your receipt of the second-level appeal review denial. You may provide additional information to be considered. ***UHC*** will acknowledge receipt of your request and notify you when your file has been sent to be reviewed. The independent reviewer will render an opinion within 60 days upon receipt of all information. If you are not satisfied with the outcome of this review, you have the right to seek legal recourse.

Important

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

Recovery of Excess Payment

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

Important

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

Section 11. Coordination of Benefits

This section defines and explains Plan provisions designed to eliminate duplicate payments and to provide the sequence in which coverage will apply (primary and secondary) when a person is covered under two plans.

Policy

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

Important

*Beginning January 1 of every year, or if you are a new enrollee, **UHC** requires an update on whether your covered dependents have other insurance. This information needs to be provided even if your dependents do not have other insurance. If you do not provide this information, **UHC** will pend the claim and request verification in writing from the **primary covered member** for other insurance. You may update your other insurance information by going online at www.myuhc.com or by calling the **UHC** Customer Service Center at 1-877-835-9855.*

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

The rules of the National Association of Insurance Commissioners (***NAIC***) for the ***coordination of benefits*** states that ***COB***:

- Applies only to group plans, not to individual insurance
- Does not apply when married persons are both members in Sandia's medical plans
- Follows the birthday rule

Use the following table to determine which plan is responsible for primary coverage and which plan is responsible for secondary coverage.

IF…	THEN…
the other plan (including HMOs) does not have a COB provision,	the plan with no COB provision is primary.
both plans have COB provisions,	the plan covering the person as an employee is primary and pays 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.
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 pays benefits first. The plan covering the other parent is secondary and pays the remaining costs to the extent of coverage.
both plans have COB but neither plan uses the birthday rule for dependent children's coverage,	the male-female rule applies. The rule says the father's group insurance is the primary plan and pays benefits first. The mother's group insurance is secondary and pays the remaining costs to the extent of her coverage.
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 the father's group insurance is the primary plan and pays benefits first. The mother's group insurance is secondary and pays the remaining costs to the extent of her coverage.
a divorce or legal decree establishes financial responsibility for health care for the covered dependent children,	the parent who has the responsibility will be the holder of the primary plan.
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.
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.
a divorce decree does not establish financial responsibility, and the parent with custody remarries,	the custodial parent's plan remains primary; the step-parent's plan is secondary; the noncustodial parent's plan is third.
payment responsibilities are still undetermined,	the plan that has covered the patient for the longest time is the primary plan.

Coordination of Benefits with Medicare

Sandia interfaces with ***Medicare*** to eliminate duplicate payments and to provide a sequence in which coverage applies. Generally, ***Medicare*** provides primary coverage for those not covered by the Plan by reason of current employment.

Note: For ***coordination of benefits*** information with ***Medicare***, refer to the ***UHC*** Senior Premier ***PPO*** Plan.

Important

*If you are eligible for **Medicare primary** coverage and are covered under this Plan (under the continuation provisions under **COBRA** or as a result of end-stage renal disease), **Medicare** is considered your primary coverage and benefits are coordinated with **Medicare** as though you have both **Medicare** Parts A and B (whether or not you enrolled in Parts A and B). If it is later determined that you became eligible for **Medicare primary** coverage and continued coverage under this Plan, and Sandia paid benefits on a primary basis, the Plan will retroactively coordinate benefits with **Medicare**. If the Plan is unable to recover reimbursement from **Medicare** or the provider, you will be responsible for reimbursing the Plan. Refer to Appendix A, Prescription Drug Program, for information on prescription drug benefits under this Plan and **Medicare** Part D.*

Subrogation and Reimbursement Rights

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

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

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

- The ***claims administrator*** will recover payments only to the extent that Plan benefits paid for treatment were provided as a result of the ***injury*** or condition giving rise to the claim.

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

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

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

Section 12. When Coverage Stops

This section outlines when coverage stops for employees and Class I and Class II dependents, as well as causes for termination by the ***claims administrator***. See Section 13, Continuation of Coverage, for specific rules governing when health coverage stops and how it may be continued for the above referenced groups.

Active Employees

Plan benefits for active employees end on the:

- Last day of the month that the employee's leave of absence or termination of employment becomes effective, except as provided under temporary continuation of coverage under ***COBRA*** or provided by law or by the provisions of this ***SPD***
- Date the Plan is terminated
- Last day of the month in which any cost of the coverage is not paid when due
- Date of death
- Last day of the month before the month in which the covered person becomes eligible for ***Medicare primary*** coverage (with some exceptions). Contact Sandia ***HBES*** for more information.
- Submission of a fraudulent claim

Important

*Health care coverage may be continued in some situations (refer to Section 13, Continuation of Group Health Coverage, for **COBRA** rules). Also, special rules apply to leaves of absence for family and medical care (Family and Medical Leave Act of 1993) and for military service (Uniformed Services Employment and Reemployment Rights Act of 1994).*

Class I and Class II Dependents

Plan benefits for dependents stop on the:

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

- Last day of the month in which the ***primary covered member*** terminates (disenrolls) dependent coverage

> **Note:** You must disenroll your dependents within 31 calendar days of the date he/she becomes ineligible for coverage under this Plan. If you fail to do so, there may be severe consequences. Refer to Section 3, Enrollment and Disenrollment, for more information.

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

Termination for Cause

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

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

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

Certificate of Group Health Plan Coverage

Sandia complies with the requirements of the Health Insurance Portability and Accountability Act (***HIPAA***), Pub. L. 104–191, that was enacted on August 21, 1996. ***HIPAA*** amended the Public Health Service Act (PHS Act), the Employee Retirement Income Security Act of 1974 (***ERISA***), and the Internal Revenue Code of 1986 (***IRC***) to provide for, among other things, improved portability and continuity of health insurance coverage

in the group and individual insurance markets, and group health plan coverage provided in connection with employment.

When the Sandia ***HBES*** learns of your loss of medical coverage, or the loss of coverage for your dependents, you will receive a Certificate of Group Health Plan Coverage. This certificate provides proof of your prior health care coverage for the past 18 months or less of coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the six-month period before your enrollment in the new plan. If you become covered under another group health plan, check with the ***plan administrator*** to see if you need to provide this certificate. You may also need this certificate to buy an insurance policy for yourself or your family that does not exclude coverage for medical conditions that are present before you enroll. You also have the right to request (up to two years following the event that caused the loss of coverage) a Certificate of Group Health Plan Coverage by contacting Sandia ***HBES*** at (505) 844-4237.

Section 13. Continuation of Group Health Coverage

This section outlines the opportunities that Sandia gives the employee, the employee's spouse or former spouse, and/or the employee's dependent children to continue health coverage through Sandia where group health coverage would otherwise end.

Continued health coverage through Sandia is subject to the stated qualifications and requirements of participation in each Sandia health plan. Sandia offers the following covered members the opportunity to continue group health coverage when their coverage under the Plan would otherwise end:

- Employees on a leave of absence
- Employees who retire
- Employees who are approved for and receiving long-term disability benefits through Sandia
- Surviving spouse and dependents
- ***COBRA*** eligible persons

> **Note:** Sandia offers continued health coverage to its retirees and dependents, ***long-term disability terminees*** and dependents, surviving spouses of employees and/or retirees, and dependents under medical plans but not through the ***UHC*** Standard ***PPO***. For more information, contact Sandia ***HBES*** at (505) 844-4237.

During Leaves of Absence

If you take a leave of absence, you are eligible to continue the same health coverage you had as an active employee. You will be allowed to change your medical plan choice every year during the ***open enrollment*** period Sandia holds in the fall.

> **Note:** Refer to ***CPR*** 300.6.18, Leaves of Absence, for more detail.

Sandia offers you an opportunity to continue your employer-provided medical care plan while you are on the following approved leaves of absence:

- Child Care – to care for a newborn child, a newly adopted child, or a newly placed foster child
- Family Care – to care for a seriously ill or injured family member
- Military Service – for service in the Uniformed Services of the United States or with the National Guard

- Tribal Government Appointments – to accept a tribal government appointment (tribal governor, lieutenant governor, tribal secretary, tribal treasurer)
- Personal – to take care of urgent personal matters
- Personal (Educational) – to pursue higher education goals
- Special – to accept assignment with the government, another DOE contractor, or a college or university

Refer to Section 4, Group Health Plan Premiums, for information on the costs you will pay for leaves of absence. Contact Sandia ***HBES*** at (505) 844-4237 for more information.

Important

*Coverage during the leave of absence runs concurrently with (i.e., applies toward) the temporary continued coverage under **COBRA**. If you terminate employment at the end of the leave of absence, additional coverage months may be available under **COBRA** depending on the number of months taken for the leave of absence. You will receive a **COBRA** notice and election at the time your leave of absence begins (as described under **COBRA** later in this section) and you will need to submit that election in order to take advantage of continued coverage during a leave of absence.*

Retiree Medical Plan Option

If you retire from Sandia with a service pension or a disability pension, you are eligible for continued medical coverage through Sandia under the Retiree Medical Plan Option. For information, contact Sandia ***HBES*** at (505) 844-4237.

As an alternative to electing coverage under the Retiree Medical Plan Option, the retiree may elect to temporarily continue the same health coverage as available to active employees by making an election under ***COBRA***. Refer to ***COBRA*** in this section for more information. If the retiree elects ***COBRA*** coverage instead of coverage under the Retiree Medical Plan Option, the retiree cannot elect the Retiree Medical Plan Option after their ***COBRA*** coverage has terminated. If the retiree elects the Retiree Medical Plan Option, he/she must waive his/her rights to ***COBRA*** as it is an either/or option.

Long-Term Disability Terminee Medical Plan Option

If you terminate employment because of a disability and you are approved for and receiving long-term disability benefits through Sandia, you are eligible for continued medical coverage through Sandia until the end of the month in which you recover and the Plan benefit ceases, the Plan benefit ceases for any other reason, or you die. For information, contact Sandia ***HBES*** at (505) 844-4237.

As an alternative to electing coverage under the ***Long-term Disability Terminee*** Option, the ***long-term disability terminee*** may elect to temporarily continue the same health coverage as available to active employees by making an election under ***COBRA***. Refer to ***COBRA*** in this section for more information. If the ***long-term disability terminee*** elects ***COBRA*** coverage instead of the ***Long-term Disability Terminee*** Option, the terminee cannot elect the ***Long-term Disability Terminee*** Option after ***COBRA*** coverage terminates. If the terminee elects the ***Long-term Disability Terminee*** Option, he/she waives rights to ***COBRA***, as it is an either/or option.

Surviving Spouse Medical Plan Option

If you are a dependent of an on-roll regular employee who dies while covered under this Plan, you are eligible to continue medical coverage through Sandia through the Surviving Spouse Medical Plan Option. For information, contact Sandia ***HBES*** at (505) 844-4237.

As an alternative to electing coverage under the Surviving Spouse Option, the surviving spouse and dependents may elect to temporarily continue the same health coverage as available to active employees by making an election under ***COBRA*** (refer to ***COBRA*** in this section for more information). If the surviving spouse elects ***COBRA*** coverage instead of the Surviving Spouse Option, the surviving spouse cannot elect the Surviving Spouse Option after ***COBRA*** coverage terminates. If the surviving spouse elects the Surviving Spouse Option, he/she waives rights to ***COBRA***, as it is an either/or option.

COBRA

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

A ***COBRA qualified beneficiary*** may continue health coverage through Sandia by notifying Sandia of a qualifying event (other than termination, reduction of hours, or death of an employee), who qualifies, electing ***COBRA*** coverage, and paying the applicable ***COBRA*** rate in a timely manner for health coverage plus a two percent administrative fee. These individuals are referred to as ***qualified beneficiaries***.

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

If you are eligible for ***Medicare primary*** coverage and are covered under this Plan (under the continuation provisions under ***COBRA***), ***Medicare*** is considered your primary cover-

age and benefits are coordinated with ***Medicare*** as though you have ***Medicare*** Parts A and B (whether or not you do). If it is later determined that you became eligible for ***Medicare primary*** coverage and continued coverage under this Plan and Sandia paid benefits on a primary basis, the Plan will retroactively coordinate benefits with ***Medicare***. If the Plan is unable to recover reimbursement from ***Medicare*** or the provider, you are responsible for reimbursing the Plan. Refer to Appendix A, Prescription Drug Program, for information on prescription drug benefits under this Plan and ***Medicare*** Part D.

Qualifying Events Causing Loss of Coverage

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

You are the qualified beneficiary if you are the…	and if you, a covered member, lose coverage under this Plan due to…	your maximum period of continuation coverage is…
Employee Spouse Dependent Child	Termination of employee's employment for any reason other than gross misconduct or reduction in employee's hours of employment	18 months*
Employee Spouse Dependent Child	Termination of employment (for any reason other than gross misconduct or reduction in employee's hours of employment), and you are disabled or become disabled within the first 60 days of your COBRA coverage, as determined by Social Security, and you do not have Medicare coverage.	29 months from the original COBRA qualifying event (after the first 18 months you will be charged 150 percent of the cost of the applicable group rate).
Spouse Dependent Child	• Covered employee becomes entitled to Medicare • Divorce or legal separation of the spouse from the covered employee • Death of the covered employee	36 months
Dependent Child	• Loss of dependent child status under the plan rules	36 months

*You may become entitled to an 18-month extension (giving a total maximum period of 36 months of continuation coverage) if you experience a second qualifying event such as the death of an employee, the divorce or legal separation of the employee and spouse, the employee becomes entitled to Medicare, or a loss of dependent child status under the plan. The second event can be a second qualifying event only if it would have caused you to lose coverage under the plan in the absence of the first qualifying event. If a second qualifying event occurs, you will need to notify the Sandia HBES.

Notification of Election of COBRA

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

Step	Who	Action
1	Employee or family member	Notify Sandia Benefits in writing within 60 days[1] after the date on which the following qualifying event occurs: • Divorce • Legal separation • Annulment • Loss of child's dependent status • Disability designation by Social Security Sandia National Laboratories Attention: Benefits, Mail Stop 1022 Albuquerque, NM 87185
2	Sandia Benefits	Notify Sandia Benefits COBRA administrator of covered member's qualifying event (including termination or reduction of hours of employment, death of employee, etc).
3	Sandia Benefits COBRA administrator	Notify qualified beneficiaries of their right to continue employer-provided health coverage and how to make an election. The notice must be provided to the qualified beneficiaries within 14 days after the COBRA administrator receives the notice of a qualifying event. Contact the COBRA administrator by calling Sandia HBES at (505) 844-4237.
4	Qualified Beneficiary	Contact the Sandia Benefits COBRA administrator to elect COBRA coverage. • Qualified beneficiary has 60 days to elect COBRA starting from the later of the date you are furnished the COBRA rights notice or the date you would lose coverage • Qualified beneficiary must make initial premium payment within 45 days from the COBRA election date. The plan allows a 30-day grace period for monthly premium payment thereafter. • If beneficiary elects to continue coverage, Sandia provides coverage under the Plan at his/her expense plus the applicable administrative fee

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

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

Benefits Under Temporary Continuation Coverage

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

- Identical coverage that is currently available under the plan to similarly situated employees and their families
- Same benefits, choices, and services that a similarly situated participant or beneficiary is currently receiving under the plan, such as the right during the annual ***open enrollment*** period Sandia holds each fall to choose among available coverage options
- Subject to the same rules and limits that would apply to a similarly situated participant or beneficiary, such as ***copayment*** requirements, ***deductibles***, and coverage limits. The plan's rules for filing benefit claims and appealing any claims denials also apply.

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

Termination of Temporary Continuation Coverage

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

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

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

Disability Extension and Multiple Qualifying Events

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

- If an individual is disabled, as determined by Social Security, before or during the first 60 days of an 18-month ***COBRA*** period, the individual's ***COBRA***-eligible family is eligible for an 11-month extension of coverage up to a maximum of 29 months from the original ***COBRA*** qualifying event. After the first 18 months of ***COBRA*** coverage, the individual will be charged at 150 percent of the cost of the applicable group rate.
    - The individual must provide a copy of the Social Security determination within 60 days of the date the disability determination was made and no later than 18 months after the election change event. He/she must also provide notice within 30 days of determination that the ***qualified beneficiary*** is no longer disabled.
- In the event of a second election change event (e.g., divorce, employee dies or becomes covered by ***Medicare***, dependent ***child*** loses dependent status) that occurs during the 18-month ***COBRA*** coverage period (or during disability extension), the spouse and children already receiving continuation coverage may be eligible for additional months of coverage, up to a maximum of 36 months from the date of the original election change event. The employee must notify Sandia Benefits of the second election change event within 60 days.

Appendix A. Prescription Drug Program

The Prescription Drug Program (***PDP***), although part of the ***UHC*** Standard ***PPO***, is administered separately by Catalyst Rx. Any licensed provider is legally authorized to prescribe medications to issue your prescription.

Important

*If you are eligible for **Medicare primary** coverage, refer to the **UHC** Senior Premier **PPO** Summary Plan Description for information on **Medicare** Part D prescription drug coverage.*

The following chart summarizes the ***copayments*** and ***coinsurances*** with minimum and maximum ***copayments*** as well as coverage for purchases under the Mail-Order Program and the Catalyst Rx network and out-of-network retail pharmacies.

Mail-Order Program	Catalyst Rx Network Retail Pharmacies	Out-of-Network Retail Pharmacies
For maintenance prescription drugs $18 copayment for generic prescription drugs $65 copayment for preferred brand-name prescription drugs $100 copayment for non-preferred brand-name prescription drugs Maximum of 90-day supply	Coinsurance of 20% of retail discount price with a $6 minimum and $12 maximum for generic prescription drugs Coinsurance of 30% of retail discount price with a $25 minimum and $40 maximum for preferred brand-name prescription drugs Coinsurance of 40% of retail discount price with a $40 minimum and $60 maximum for non-preferred brand-name prescription drugs Maximum of 30-day supply	50% reimbursement of retail network price, less the applicable minimum retail network copayment Maximum of 30-day supply File your claims with Catalyst Rx Coinsurance does not apply to UHC Standard PPO deductible and out-of-pocket maximum
Important: If the cost of the prescription is less than the copayment, you will pay only the actual cost of the prescription. Copayments do not apply to UHC Standard PPO deductible and/or out-of-pocket maximum. Reimbursement for prescriptions purchased outside the United States will be reimbursed down to the applicable retail copay, limited to a maximum of a 30-day supply.		

Preferred Versus Non-preferred Status

Catalyst Rx maintains a Preferred Drug List (also known as a ***formulary***). Medications listed on the Preferred Drug List are selected according to safety, efficacy (whether the drug works for the indicated purpose), therapeutic merit (how appropriate the drug is for the treatment of a particular condition), current standard of practice, and cost. If a brand name drug appears on this List, then you will pay the cost for the preferred brand-name prescription drugs as outlined above. If a brand name drug does not appear on this List, then you will pay the cost for the non-preferred brand name drugs as outlined above. Deletions to the Preferred Drug List are made on an annual basis with an effective date of January 1. Additions to the List are made quarterly.

The Preferred Drug List is the same for both the Mail-Order Program and the retail network pharmacies and is comprehensive for all major categories of acute and maintenance medication. To find out if a drug qualifies as a preferred brand name drug, you can either call Catalyst Rx at 866-854-8851 or look on the web at www.catalystrx.com (user ID: SNL; Password: SNL). Drugs listed on the Catalyst Rx Preferred Drug List may or may not be covered under the ***PDP***. Refer to the Covered/Noncovered Drugs Sections.

If, for some reason, you are unable to take any of the preferred alternatives, you, your pharmacist or your doctor can initiate a Prior Authorization (PA) by contacting Catalyst Rx directly and requesting a PA for the medication. Catalyst Rx will contact your doctor and request the information necessary for a non-preferred brand name drug. Catalyst Rx will review the letter and make the decision as to whether you will be able to receive the nonpreferred drug for the preferred brand-name ***coinsurance***/ ***copayment*** amount.

Eligibility

Members eligible for coverage under the ***UHC*** Standard ***PPO*** Plan are eligible for the ***PDP***. ***UHC*** Standard ***PPO*** members who have primary prescription drug coverage under another group health care plan or Medicare are not eligible to use the Mail-Order Program or purchase drugs from retail network pharmacies at the ***copayment*** benefit.

Coordination of benefits applies. If you or your dependent has primary prescription drug coverage elsewhere, file the claim first with the appropriate plan, and then file with Catalyst Rx, attaching a copy of the ***EOB***. Catalyst Rx will allow 50 percent of the price submitted, with no days-supply limit, up to the amount the member pays out-of-pocket.

Important

*If you are enrolled in a Medicare Part D plan, refer to the **UHC** Senior Premier **PPO** Summary Plan Description for information on how your Part D Plan may coordinate with your coverage under the UHC Standard PPO Plan.*

Identification Cards

If you are a new enrollee in the ***UHC*** Standard ***PPO*** Plan, you will receive new Catalyst Rx ***ID*** cards. If you need additional identification cards, you may call Catalyst Rx Customer Service at 866-854-8851 and request them.

Important

Always present your Catalyst Rx ID card when obtaining prescriptions at a retail pharmacy. If you do not use your card, you are not eligible to receive reimbursement for the prescription.

Covered Prescriptions

Important

*FDA approval of a drug does not guarantee inclusion in the **PDP**. New drugs may be subject to review before being covered under the **PDP** or may be excluded based on plan guidelines and policies.*

To be covered, the prescription must be considered ***medically necessary***. The ***PDP*** covers the following categories of drugs:

- Federal Legend Drugs — A medicinal substance that bears the legend "Caution: Federal Law prohibits dispensing without a prescription"
- State Restricted Drugs — A medicinal substance that, by state law, may be dispensed by prescription only
- Compounded Medications — A compounded prescription in a customized dosage form that contains at least one federal legend drug
- The following over-the-counter (OTC) medications/supplies:
  - Transdermal patches for smoking cessation
  - Nutritional supplements (requires a Prior Authorization (see below)
  - Insulin and Diabetic Supplies — Supplies, including lancets, alcohol swabs, ketone test-strips (both blood and urine), and syringes, can be purchased in-network with a prescription and with a ***copayment***, or in-network without a prescription by paying the full price and submitting the claim to Catalyst Rx for reimbursement. (You will be reimbursed down to the appropriate ***copayment***.) The Mail-Order Program is also available for insulin and diabetic supplies purchased with a prescription.

Note: ***Medicare*** covers lancets and test strips.

- The following prescription devices/supplies:
  - Insulin auto-injectors
  - Lancet auto-injectors
  - Glucagon auto-injectors (see A-5)
  - Epi-Pens (see A-5)
  - Aero-chambers, aero-chambers with masks, nebulizer masks

Note: The PDP covers immunizations obtained and/or administered at retail network pharmacies at no cost to the member. In addition, Catalyst Rx maintains a program whereby certified pharmacists within New Mexico are licensed to prescribe and administer certain vaccinations. To inquire about this Program, contact Catalyst Rx at 866-854-8851.

Prescriptions Requiring Prior Authorization

A Prior Authorization, also known as a PA, is a clinical program that ensures appropriate use of prescription medications. You, your pharmacist or your doctor can initiate a PA for the medication by contacting Catalyst Rx directly and requesting a Prior Authorization for the medication. Medications subject to a PA require pre-approval from

the Catalyst Rx Prior Authorization Team before they can qualify for coverage under this Plan. The following prescriptions or therapeutic class of prescriptions are subject to the Prior Authorization process. This list is not all inclusive and is subject to change.

- Acne products for members 26 and older (e.g. Retin A/Renova/Differen/Avita)
- Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD) agents for members over the age of 17 (e.g. Ritalin)
- Anabolic steroids (e.g. Anadrol)
- Anorexiant agents (e.g. Meridia)
- Biologicals–immune globulins (e.g. Gamimune N)
- Botox
- Growth hormones (e.g. Humatrope)
- Nutritional supplements (e.g. Ensure, Phenyl-Free)
- Osteoarthritis agents (e.g. Synvisc)
- Prescription vitamins (other than pediatric and prenatal)
- Rebetron
- Synagis
- Thyrogen
- Zyvox
- Prescriptions that cost over $1,000 at retail and $3,000 at mail

Prescriptions Subject to Step Therapy Program

Step Therapy is a program designed to encourage the safe and cost-effective use of medication. Step Therapy requires that you try a "first-line medication" before a "second-line medication" will be covered. Drugs considered first-line therapy are well-supported treatment options and represents the most cost-effective agent for a given condition. The following prescriptions or therapeutic class of prescriptions are subject to the Step Therapy process. This list is not all-inclusive and is subject to change.

- Remicade
- Revatio
- Byetta
- Symlin
- Viracept

Prescriptions Subject to Quantity Limits

A Quantity Limit is a limitation on the number (or amount) of a prescription medication covered within a certain time period. Quantity Limits are established to ensure that prescribed quantities are consistent with clinical dosing guidelines, to control for billing errors by pharmacies, to encourage dose consolidation, appropriate utilization and to avoid misuse/abuse of the medication. Established quantity limits are based on the Federal Drug Administration and manufacturer dosing recommendations and/or current literature. Prescriptions written for quantities in excess of the established limits will

require a Prior Authorization (see A-3) before the prescription can be filled. The following prescriptions or therapeutic class of prescriptions are subject to Quantity Limits. This list is not all-inclusive and is subject to change.

- Emergency contraceptive (e.g. Plan B) limited to two per year
- Epi-Pen (limit to three per year)
- Glucagon auto-injection (limit to two per year)
- Insulin auto injectors (limit to two per year)
- Lovenox (limit to seven days/14 injections)
- Nicotrol Nasal Spray (three inhaler kits per 30 days with a maximum of 360 days per lifetime)
- Sexual dysfunction drugs (e.g. Viagra) are limited to males only and eight pills/30 days at retail or 24 pills/90 days at mail
- Sleep aids (e.g. Ambien) are limited to 15 pills/30 days at retail or 45 pills/90 days at mail (limitation is waived if dispensed by a physician who is a sleep specialist as determined by Catalyst Rx)
- Relenza diskhaler (one per year)
- Tamiflu (ten capsules per year)

Noncovered Prescriptions

In addition to the clinical guideline limitation imposed by Catalyst Rx (see Covered Prescriptions, A-4), the ***PDP*** excludes coverage for certain drugs, supplies, and treatments, which include but are not limited to the following:

- Over-the-counter medications unless specifically included
- Fluoride preparations and dental rinses
- Contraceptive foams, jellies, and ointments
- Drugs labeled "Caution: Limited by Federal Law to investigational use or experimental drugs"
  - Experimental drugs are defined as "a therapy that has not been or is not scientifically validated with respect to safety and efficacy."
  - Investigational drugs are defined as "those substances in any of the clinical stages of evaluation which have not been released by the Food and Drug Administration (FDA) for general use or cleared for sale in interstate commerce. It also includes those drugs that are in any of the clinical stages of evaluation (Phase I, II, and III) which has not been released by the FDA for general use or cleared for sale in interstate commerce."
- Glucose tablets
- Drugs used for cosmetic purposes
- Prescription drugs that may be properly received without charge under local, state, or federal programs, including Workers' Compensation
- Refills of prescriptions in excess of the number specified by the ***physician***
- Refills dispensed after one year from the date of order by the ***physician***
- Prescription drugs purchased for members who are ineligible for coverage under the ***UHC*** Standard ***PPO***

- Prescription drugs taken by a donor who is not insured under this ***PPO*** Plan
- Medicine not ***medically necessary*** for the treatment of a disease or an ***injury***

The following are excluded by the ***PDP*** but may be covered by ***UHC*** if ***medically necessary***:

- Ostomy supplies
- Blood glucose meters
- Implantable birth control devices such ***IUDs***
- Allergy serum
- Insulin pumps (implantable or otherwise)
- Intravenous medications
- Medication that is dispensed and/or administered by a licensed facility or provider such as a ***hospital***, home health care agency, or ***physician's*** office, and the charges are included in the facility or provider bill to ***UHC***

Mail Service Program

Catalyst Rx partners with Walgreens Mail Service to offer a Mail Service Benefit. Walgreens Mail Service is a licensed pharmacy specializing in filling prescription drug orders for maintenance prescriptions. Maintenance prescription drugs are those taken routinely over a long period of time for an ongoing medical condition. Registered pharmacists are available 24 hours a day, seven days a week, at 1-866-854-8851, to answer patients' medication-related questions. Prescriptions are delivered to the member's home. (You are not responsible for shipping and handling fees unless you request special shipping arrangements.) To obtain a maintenance prescription through the Mail Service Program, you pay the appropriate ***copayment*** for each prescription up to a 90-day supply (see A-1).

Note: f you need medication immediately, ask your doctor for two (2) separate prescriptions – one for a 30-day supply to be filled at a network retail pharmacy, and one to be filled by mail service. Wait and send in your mail service prescription two weeks after you fill your prescription at the retail network pharmacy to avoid any delays with your mail service prescription.

Let your ***physician*** know that you are planning to use the Mail Service Program services and request a 90-day prescription (with up to three refills). Verify that the prescription specifies the exact information for daily dosage, strength, quantity (e.g., number of pills, inhalers, tubes), and number of refills.

If you send in a prescription through the Mail-Order Program and Walgreens Mail Service does not carry the medication or if it is out of stock and Walgreens Mail Service does not anticipate getting the medication in a timely manner, you will be allowed to

receive a 90-day supply at a retail network pharmacy for the applicable mail-order ***copayment***. Contact Catalyst Rx at 1-866-854-8851 for assistance.

Note: If you are a patient in a nursing home that does not accept mail-order prescriptions, contact Catalyst Rx to make arrangements to receive up to a 90-day supply of medication at a retail network pharmacy for the applicable mail-order ***copayment***. You must provide proof of residency in a nursing home.

If you are a cystic fibrosis patient, you can receive up to a 90-day supply at a Cystic Fibrosis Foundation pharmacy for the applicable mail-order ***copayment*** by contacting Catalyst Rx.

Steps for Ordering and Receiving Prescriptions

Step	Action	
1	Forms	Obtain a Walgreens Mail Service Registration & Prescription Order Form from the Sandia website or www.catalystrx.com.
2	Ordering Original Prescriptions	Complete the Walgreens Mail Service Registration & Prescription Order Form Attach your original written prescription (with your Member Identification number and address written on the back). Make sure your physician has written the prescription for a 90-day supply with applicable refills. Enclose the required copayment using a check or money order, or complete the credit card section on the form. Mail all to Walgreens Mail Service, P.O. Box 29061, Phoenix, AZ 85038-9061. Your physician may also call in the prescription to Walgreens at 1-866-854-8851 or fax it to 1-800-332-9581. Note: If you need medication immediately, ask your doctor for two (2) separate prescriptions – one for a 30-day supply to be filled at a network retail pharmacy, and one to be filled by mail service. Wait and send in your mail service prescription two weeks after you fill your prescription at the retail network pharmacy to avoid any delays with your mail service prescription.
3	Delivery	Expect delivery to your home by first-class mail or second-day carrier within seven to ten working days from the date you mail your order. An adult's signature may be required for acceptance.
4	Refills	Refilling a mail-order prescription can be done by phone, by fax, by mail, or through the web. It is recommended that you order three weeks in advance of your current mail service prescription running out. **Refill-by-Phone:** Call 1-866-854-8851 to order refills. You may use the automated refill system 24 hours a day. Customer service representatives are available Monday through Friday from 6:00 a.m. to 8:00 p.m. (MST) and on Saturday and

Step	Action	
		Sunday from 6:00 a.m. to 3:00 p.m. (MST). **Refill-by-Fax:** Have your physician complete the Fax Order Form (which is part of the Walgreens Mail Service Registration & Prescription Order Form). The physician (not the member) must fax the form to 1-800-332-9581. **Note:** Schedule II prescriptions cannot be faxed. **Refill-by-Mail:** Complete the Prescription Order Form (attached to the bottom of your customer receipt), making sure you adhere the refill label provided or write the prescription number in the space provided. Mail in the self-addressed, postage-paid envelope. **Refill through the Web:** Go to www.catalystrx.com/. On the left hand side of your screen, select "Mail Service Refills." Next, click on WalgreensMail.com on the right hand side of your screen. From there, follow the instructions to place your refill order. You must access the mail order website from www.catalystrx.com. You will need to use one of the acceptable credit cards for payment.

Brand-To-Generic Substitution

Every prescription drug has two names: the trademark, or brand name; and the chemical, or generic name. By law, both brand-name and generic drugs must meet the same standards for safety, purity, strength, and quality.

Example: tetracycline is the generic name for a widely used antibiotic. Achromycin is the brand name.

Many drugs are available in generic form. Generic drugs offer substantial cost savings over brand names; therefore, the Mail-Order Program has a generic substitution component. Unless your doctor has specified that the prescription be dispensed as written, your prescription will be filled with the least expensive acceptable generic equivalent when available and permissible by law. If you receive a generic medication in place of the brand-name medication, and you want the brand-name medication, you will need to obtain a new prescription stating "no substitution" or "dispense as written" and resubmit it along with the required ***copayment***.

EXCEPTION

This provision does not apply to brand-name drugs that do not have an FDA A- or AB-rated generic equivalent available.

Retail Pharmacies

Retail pharmacies are available for those members who need immediate, short-term prescription medications, and/or prescription medications that cannot be shipped through the mail.

Using the Network Retail Pharmacies

Catalyst Rx has contracted with specific retail pharmacies across the nation that will provide prescriptions to Sandia at discounted rates. These pharmacies are known as retail network pharmacies. To locate the pharmacy nearest you, call Catalyst Rx at 1-866-854-8851 or visit www.catalystrx.com.

To obtain a medication through a retail network pharmacy, you will need a written prescription from your doctor. Present the prescription and your Catalyst Rx *ID* card to the pharmacist. The card is required to identify you as a covered member in order to remit the appropriate ***copayment*** (see A-1). If you do not show your **ID** card at a retail network pharmacy, you will be required to pay the full nondiscounted price and you cannot submit this for reimbursement.

If you request a prescription to be filled in a retail network pharmacy for more than a 30-day supply, the pharmacist will fill only 30 days for the appropriate ***coinsurance*** of 20 percent, 30 percent, or 40 percent (minimum and maximum ***copayments*** apply) and hold the rest as refills. When you need a refill, return to the pharmacy, pay another ***coinsurance***/***copayment*** amount, and receive another maximum 30-day supply (or up to the amount prescribed by the ***physician***).

Using the Out-of-Network Retail Pharmacies

If you choose to purchase a prescription through an out-of-network pharmacy, you will be reimbursed 50 percent of the retail network price, less the applicable minimum retail ***copayment***, for up to a 30-day supply. Any amounts over a 30-day supply will be denied. Any amounts you pay do not apply to the **out-of-pocket maximum** under the **UHC** Standard **PPO** Plan.

If you have a prescription filled by an out-of-network pharmacy, complete a Direct Member Reimbursement Form, attach pharmacy receipts, and send your claim to Catalyst Rx, P.O. Box 1069, Rockville, MD 20849-1069.

Important

No claims will be paid for charges incurred more than one year before the date of the claim submission.

Timing of Claims Payments

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

- Urgent care – a claim for benefits provided in connection with ***urgent care*** services
- Pre-service – a claim for benefits which the Plan must approve before non-***urgent care*** is provided

- Concurrent care – a claim for benefits whereby the Plan had been reimbursing for the care and a determination was made that the care was no longer eligible for reimbursement
- Post-service – a claim for reimbursement of the cost of non-***urgent care*** that has already been provided.

Urgent Care Claims

Urgent claims will be decided as soon as possible. Notice of the decision (whether adverse or not) must be provided, considering medical exigencies, no later than 72 hours after receipt of the claim. If additional information is needed to make a claim decision, Catalyst Rx may extend the time frame for providing a response by up to 48 hours from the time the information is received or the initial period expires. If an extension in processing is required because the claimant has failed to submit sufficient information to allow determination of the claim, the claimant has at least 48 hours after receipt of notice to provide missing information. Notice that a claim is improperly filed or is missing information must be provided as soon as possible but no later than 24 hours from receipt of claim.

Pre-service Claims

Pre-service determination of benefit (whether adverse or not) must be provided within a reasonable period of time, appropriate to medical circumstance, but no later than 15 days. Catalyst Rx may extend the original time frame by up to 15 days if necessary due to matters beyond the Plan's control. Catalyst Rx must provide an extension before the initial period ends. If an extension in processing is required because the claimant has failed to submit sufficient information to allow determination of the claim, the claimant will be so notified and given at least 45 days from the notice to provide missing information.

Post-service Claims

Post-service claim decisions notices (whether adverse or not) must be provided within a reasonable period of time but no later than 30 days. Catalyst Rx may extend the original time frame by up to 15 days if necessary due to matters beyond the Plan's control. Catalyst Rx must provide an extension notice before the initial period ends. If an extension in processing is required because the claimant has failed to submit sufficient information to allow determination of the claim, the claimant will be so notified and given at least 45 days from receipt of the notice to provide missing information.

Concurrent Care Claims

Concurrent care adverse claim decisions must be provided sufficiently in advance to give claimants an opportunity to appeal and obtain a decision before the benefit is reduced or terminated. A request to extend a course of treatment will receive a response within 24 hours, if the claim is made at least 24 hours prior to the expiration of the period of time or

number of treatments. The Plan provides that the benefit reimbursement be maintained for up to 60 calendar days from the date of the first letter of denial for sufficient time for the member to appeal.

Contents of Notice and Response from Catalyst Rx

The notice (known as an Adverse Determination) will include all of the following:

- The specific reason for the denial
- Specific references to the Plan provisions upon which the denial is based
- A description of any additional material or information necessary for the claimant to perfect the claim
- A description of the appeal procedures/rights afforded the member, their representative or prescriber, on behalf of the member. This information will be set forth in writing and sent to the member, their representative or to the prescriber, on behalf of the member.

Claim Denials and Appeals

If you have a claim denied because of . . .	then . . .
coverage eligibility (except for disability determinations)	contact Sandia HBES at (505) 844-HBES (4237).
Pharmacy benefits administration or any other medication benefit reason	contact Catalyst Rx at 1-866-854-8851

Filing an Appeal

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

Important

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

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

- patient's name and Social Security number
- provider's name
- reason your claim should be paid
- any documentation or other written information to support your request

You, or your doctor, can send the written appeal via fax at 1-888-852-1832 or by mail to:

Catalyst Rx
Attention: Appeals Process

1650 Spring Gate Lane
Las Vegas, NV 89134

Three Levels of Appeal

Three levels of appeals are permitted for each type of claim that is denied (called an Adverse Determination):

a. An Adverse Determination must be appealed within 180 calendar days of receipt of the Adverse Determination. An appeal may be filed by the member, their representative, or by a prescriber (on behalf of the member).
b. The member, their representative or prescriber, on behalf of the member, may submit written comments, documents, records and other information relevant to the member's request for an appeal. All such information is taken into account during the appeal process without regard to whether such information was submitted or considered when making the initial Adverse Determination.
c. Upon initially receiving an appeal a clinical pharmacist will review the appeal (1st level) and may overturn the initial Adverse Determination, if appropriate. If the initial Adverse Determination is overturned, the member and prescriber, if the prescriber filed the appeal on behalf of the member, will be notified of the determination in writing.
d. If the clinical pharmacist does not overturn the Adverse Determination, Catalyst Rx will forward the appeal request to a physician (2nd level) in the same profession and in a similar specialty that typically manages the medical condition, procedure, or treatment as mutually deemed appropriate. The physician reviewer will make the appeal determination. The clinical pharmacist completing the review of the appeal and the reviewing physician will each hold an active, unrestricted license and board certification, if applicable, by the American Board of Medical Specialties (doctors of medicine) or the Advisory Board of Osteopathic Specialists (doctors of osteopathic medicine).
e. If you are not satisfied with the decision following completion of the second-level appeal process, you may request that Catalyst Rx forward your appeal request to the current independent review organization; MCMC LLC. You must submit this request within 180 calendar days of your receipt of the second-level appeal review denial. MCMC LLC will engage a physician (3rd level) in the same profession and in a similar specialty that typically manages the medical condition, procedure, or treatment as mutually deemed appropriate. The physician reviewer will make the appeal determination. The reviewing physician will hold an active, unrestricted license and board certification, if applicable, by the American Board of Medical Specialties (doctors of medicine) or the Advisory Board of Osteopathic Specialists (doctors of osteopathic medicine).
f. As with any Adverse Determination, approved clinical criteria will be employed to evaluate the claim under review during an appeal.
g. If within 5 working days after the filing date of the appeal there is not sufficient information to process the appeal, the member, their representative or the prescriber, who filed the appeal on behalf of the member, will be notified by written

communication of the information required in order to process the appeal and directions on how to resubmit the appeal.

h. Appeal determinations are rendered as follows:
   - 1st level appeal - within 15 calendar days of the filing date
   - 2nd level appeal - within an additional 15 calendar days of the filing date of the 1st level appeal
   - 3rd level appeal – within 30 calendar days of the filing date of the 3rd level appeal

i. If any of the appeal reviews overturns the Adverse Determination, the benefit will be allowed.

Expedited Appeal

a. An expedited appeal may be filed by a member, their representative or a prescriber, acting on behalf of a member.
b. The clinical pharmacist or physician reviewer, in discussion with the member and/or independent third party review organization, will determine whether the appeal constitutes an expedited appeal.
c. Upon initially receiving an expedited appeal, a clinical pharmacist will review the expedited appeal and may overturn the initial Adverse Determination, if appropriate. If the initial Adverse Determination is overturned, the member and prescriber, on behalf of the member, will be notified of the outcome in writing.
d. If the clinical pharmacist upholds the Adverse Determination, Catalyst Rx will forward the appeal request to the current independent review organization; MCMC LLC, which will engage a physician in the same profession and in a similar specialty that typically manages the medical condition, procedure, or treatment as mutually deemed appropriate. The physician reviewer will make the Appeal determination. The clinical pharmacist completing the review of the appeal and the reviewing physician will each hold an active, unrestricted license and board certification, if applicable, by the American Board of Medical Specialties (doctors of medicine) or the Advisory Board of Osteopathic Specialists (doctors of osteopathic medicine).
e. If within 24 hours after the filing date of the expedited appeal, there is not sufficient information to process the appeal, the member, their representative or the prescriber, who filed the appeal on behalf of the member, will be notified verbally with a follow up in writing of the information required in order to process the appeal and directions on how to resubmit the appeal.
f. The decision on an expedited appeal will be rendered and communicated verbally within 72 hours of receipt of the appeal request.

Important

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

Important

In performing its obligation to process and adjudicate claims for plan benefits, Catalyst Rx shall act as a fiduciary, as defined by and in compliance with applicable provisions of ERISA. Sandia accordingly delegates to Catalyst Rx and any subcontractors, including an independent third party review organization, the discretionary authority necessary to fulfill this role. As the claims fiduciary, Catalyst Rx has the sole authority and discretion to determine whether submitted services/costs are eligible for benefits and to interpret, construe, and apply the provisions of the Plan (with the exception of member eligibility provisions which, except for incapacitated dependent status, are determined by Sandia) in processing and adjudicating claims. For final appeal of pharmacy benefit determinations, Catalyst Rx has contracted with an independent third party review organization that will assume fiduciary responsibility for these appeals. Either the determinations of Catalyst Rx or the independent third party review organization, whichever is applicable, shall be conclusive and not subject to review by Sandia.

Appendix B. Members Rights and Responsibilities

This information is provided to assist members in dealings with ***UHC*** and providers. Although problems arising with providers under these guidelines should be reported to ***UHC*** at 1-877-835-9855 and to Sandia ***HBES*** at 505-844-HBES (4237), neither ***UHC*** nor Sandia is responsible for nor can they guarantee cooperation from all providers in these matters.

You have the right to:

1. Be treated with respect and dignity by ***UHC*** personnel and network ***physicians*** and providers
2. Privacy and confidentiality for treatments, tests or procedures you receive
3. Voice concerns about the service and care you receive
4. Register complaints and appeals concerning your health plan or the care provided to you
5. Receive timely responses to your concerns
6. Participate in a candid discussion with your ***physician*** about appropriate and medically necessary treatment options for your conditions, regardless of cost or benefit coverage
7. Be provided with access to health care, ***physicians***, and other health care professionals
8. Participate with your ***physician*** and other caregivers in decisions about your care
9. Make recommendations regarding the organization's member's rights and responsibilities policies
10. Receive information about ***UHC***, our services, and network ***physicians*** and other health care professionals
11. Be informed of, and refuse to participate in, any ***experimental*** treatment
12. Have coverage decisions and claims processed according to regulatory standards
13. Choose an ***advance directive*** to designate the kind of care you wish to receive should you be unable to express your wishes

You have the responsibility to:

1. Know and confirm your benefits before receiving treatment
2. Contact an appropriate health care professional when you have a medical need or concern
3. Show your ***ID*** card before receiving health care services
4. Pay any necessary ***copayment*** at the time you receive treatment
5. Use ***emergency*** room services only for ***injury*** or illness that, in the judgment of a reasonable person, requires immediate treatment to avoid jeopardy to life or health
6. Keep scheduled appointments
7. Provide information needed for your care
8. Follow agreed-upon instructions and guidelines of ***physicians*** and health care professionals
9. Participate in understanding your health problems and developing mutually agreed upon treatment goals
10. Notify Sandia of changes in address or family status
11. Visit ***UHC's*** website (www.myuhc.com) or call customer service when you have a question about your eligibility, benefits, claims, and more
12. Access the website (www.myuhc.com) or call customer service to verify that your ***physician*** or health care professional is participating in the ***UHC*** network before receiving services

Appendix C. UHC Standard PPO Acronyms and Definitions

Acronyms

COB	coordination of benefits (see definition)
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPR	Corporate Process Requirement
DME	durable medical equipment (see definition)
EAP	Employee Assistance Program
EBC	Employee Benefits Committee
EHS	Eckerd Health Services
EOB	explanation of benefits
ERISA	Employee Retirement Income and Security Act
FMLA	Family and Medical Leave Act
GIFT	Gamete intrafallopian transfer
HBES	Health, Benefits, and Employee Services
HDL	High-density lipoprotein
HIPAA	Health Insurance Portability and Accountability Act
HIV	human immunodeficiency virus
HMO	Health Maintenance Organization (see definition)
ICD-9	International Classification of Diseases – the 9th edition
ID	identification
IRC	Internal Revenue Code
IUD	intrauterine device
LDL	low-density lipoprotein

NAIC	National Association of Insurance Commissioners
PCP	primary care physician
PDP	prescription drug program
PKU	phenylketonuria
PPO	Preferred Provider Organization (see definition)
QMCSO	Qualified Medical Child Support Order
SPD	Summary Plan Description
TMJ	temporomandibular joint (see definition)
UBH	United Behavioral Health
UHC	United HealthCare
URN	United Resource Networks
ZIFT	Zygote intrafallopian transfer

Definitions

advance directive	A document that states the kinds of health care you want in the event you become unable to make decisions for yourself
alternate payee/ alternate recipient	A child or custodial parent who is not a primary covered member and who, because of a qualified medical child support order (see definition), is entitled to receive a reimbursement directly from the claims administrator
behavioral health	Mental health and/or substance abuse
business associates	UHC, CIGNA, Delta Dental, Superior Vision, PayFlex, Mercer Human Resource Consulting, Towers Perrin Consulting
child(ren)/child	Children include: • the primary covered member's or domestic partner's own children and legally adopted children • adopted child (if the placement agreement and/or final adoption papers have been completed and submitted to Sandia HBES) • stepchildren living with the primary covered member or domestic partner (stepchildren visiting for the summer are not considered to be living with you) • child for whom the primary covered member or domestic partner has legal guardianship • natural child, legally adopted child, or child for whom the primary covered member or domestic partner has legal guardianship if a court decree requires the primary covered member or domestic partner to provide coverage
claims administrator	The third party designated by Sandia to receive, process, and pay claims according to the provisions of the UHC Standard PPO. For medical claims, behavioral health and EAP claims, this is UHC; and for outpatient prescription drugs purchased through the PDP, this is PharmaCare
COBRA	Requires Sandia to offer a temporary extension of health care coverage to primary covered members and dependents who would otherwise lose their group health coverage as a result of certain events
coinsurance	Cost-sharing feature by which both the UHC Standard PPO and the covered member pay a percentage of the covered charge
congenital anomaly	A physical developmental defect that is present at birth

coordination of benefits (COB)

When a covered member has medical coverage under other group health plans (including Medicare), UHC Standard PPO benefits are reduced so that total combined payments from all plans do not exceed 100 percent of the eligible expense

copayment/copay

Cost-sharing feature by which Plan pays the remainder of the covered charge after the member pays his or her portion as a defined dollar amount

cost effective

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

cosmetic procedures

Procedures or services that change or improve appearance without significantly improving physiological function, as determined by the claims administrator. Reshaping a nose with a prominent bump is an example of a cosmetic procedure because there would be no improvement in function like breathing.

custodial care

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

- a person without medical skills or background could provide or could be trained to provide
- are provided mainly to help the member with daily living activities, including (but not limited to)
  - walking, getting in and/or out of bed, exercising, and moving the covered member
  - bathing, using the toilet, administering enemas, dressing, and assisting with any other physical or oral hygiene needs
  - assistance with eating by utensil, tube, or gastrostomy
  - homemaking, such as preparation of meals or special diets, and house cleaning
  - acting as a companion or sitter
  - supervising the administration of medications that can usually be self-administered, including reminders of when to take such medications
  - provide a protective environment
- are part of a maintenance treatment plan or are not part of an active treatment plan intended to or reasonably expected to improve the member's sickness, injury, or functional ability

- are provided for the convenience of the member or the caregiver or are provided because the member's own home arrangements are not appropriate or adequate

deductible

Covered charges incurred during a calendar year that the member must pay in full before the UHC Standard PPO pays benefits

developmental care

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

- are provided to a member who has not previously reached the level of development expected for his/her age in the following areas of major life activity:
  - intellectual
  - physical
  - receptive and expressive language
  - learning
  - mobility
  - self-direction
  - capacity for independent living
  - economic self-sufficiency
- are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to injury or sickness)
- are educational in nature.

dual Sandian

Both spouses are employed by or retired from Sandia National Laboratories

durable medical equipment (DME)

Equipment determined by UHC to meet the following criteria:

- prescribed by a licensed physician
- medically appropriate
- not primarily and customarily used for a nonmedical purpose
- designed for prolonged use
- serves a specific therapeutic purpose in the treatment of an injury or sickness.

Employee Assistance Program (EAP) counselor

A licensed master's or PhD-level mental health clinician who provides information, assessment, short-term counseling, and referral

eligible expenses

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

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

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

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

emergency

See medical emergency

experimental or investigational (applicable to UHC, UBH, and PharmaCare)

Experimental or investigational drug, device, treatment or procedure means

- a drug or device that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and that has not been so approved for marketing at the time the drug or device is furnished
- a drug, device, treatment, or procedure that was reviewed and approved (or that is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function, or a drug, device, treatment, or procedure that is used with a patient informed consent document that was reviewed and approved (or that is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function
- a drug, device, treatment, or procedure that reliable evidence shows is the subject of ongoing phase I, II, or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis

- a drug, device, treatment, or procedure for which the prevailing opinion among experts, as shown by reliable evidence, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

If you have a sickness or injury that is likely to cause death within one year of the request for treatment, UHC may, at its discretion, determine that an experimental and investigational service is a covered health service for that sickness or injury. For this to take place, UHC must determine that the procedure or treatment is:

- proved to be safe and promising
- provided in a clinically controlled research setting
- using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health

(See also "reliable evidence.")

financially dependent persons

Persons who receive more than 50 percent of their support from the primary covered member for the calendar year

formulary

A list of preferred brand-name drugs that can meet a patient's clinical needs at a lower cost than other brand-name drugs

global charge

The single expense incurred for the combination of all necessary medical services normally furnished by a physician or other covered providers (or multiple physicians or other covered providers) before, during, and after the principal medical service. The global charge will be based on a complete description of the covered medical service rather than a fragmented description of that service.

The determination of what is included in the global charge will be made by the claims administrator.

Health Care Reimbursement Spending Account (RSA)

Used to help pay for health care expenses not reimbursed or only partially reimbursed by any medical, dental, vision plan, or other health insurance plan. This account can be used by active employees only.

Health Maintenance Organization (HMO)

An affiliation of health care providers offering health care to enrollees

home health aide services

Include (but are not limited to) helping the covered member with

- bathing and care of mouth, skin, and hair
- bowel and bladder care
- getting in and out of bed and walking
- exercises prescribed and taught by appropriate professionals
- medication ordered by a physician
- household services essential to the home health care (if the services would be performed if the covered member were in a hospital or skilled nursing facility)
- reporting changes in the covered member's condition to the supervising nurse.

hospice

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

hospital

An institution operated as required by law that is:

- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance abuse, diagnostic and surgical facilities, by or under the supervision of a staff of physicians and
- has 24-hour nursing services

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

injury

Bodily damage from trauma other than sickness, including all related conditions and recurrent symptoms

inpatient stay

An uninterrupted confinement of at least 24 hours following formal admission to a hospital, skilled nursing facility, or inpatient rehabilitation facility

intensive outpatient stays/program

A program that provides 9 to 20 hours per week (less than 4 hours per day) of professionally directed evaluation and/or treatment

jaw joint disorder (TMJ)

Any misalignment, dysfunction, or other disorder of the jaw joint (or of the complex of muscles, nerves, and tissues related to that joint). It includes temporomandibular joint (TMJ) dysfunction, arthritis, or arthrosis; other craniomandibular joint disorders; and myofascial or orofacial pain syndrome. It does not include a fracture or dislocation that results from an injury.

long-term disability terminee

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

maintenance care

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

medically appropriate/ medical appropriateness (applicable to UHC and/or UBH)

A service or supply that is ordered by a physician, the medical director, and/or a qualified party or entity selected by UHC and/or UBH, and determined as

- provided for the diagnosis or direct treatment of an injury or sickness
- appropriate and consistent with the symptoms and findings or diagnosis and treatment of the member's injury or sickness
- provided in accordance with generally accepted medical practice on a national basis
- the most appropriate supply or level of service that can be provided on a cost-effective basis, including but not limited to inpatient vs. outpatient care, electric vs. manual wheelchair, surgical vs. medical, or other types of care
- allowable under the provisions of the UHC Standard PPO as prescribed by the member's physician.

Important

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

medical emergency

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

medically necessary medical necessity (applicable to the prescription drug program only)

- Appropriate for the symptoms, diagnosis, or treatment of the eligible person's condition
- provided for the diagnosis, direct care, or treatment of the eligible person's condition
- not primarily for the convenience of the eligible person and/or the provider
- the most appropriate supply or level of service that safely can be provided to the eligible person

Important

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

Medicare — A federal program administered by the Social Security Administration that provides benefits partially covering the cost of necessary medical care

Medicare eligible — The member is eligible to enroll in Medicare Parts A and B regardless of whether he or she has enrolled

Medicare primary (also referred to as primary Medicare) — The member is eligible to receive Medicare benefits first before Sandia's plan is required to pay, regardless of whether the member has enrolled in Medicare

mental or nervous disorder — Any condition or disease, regardless of its cause, listed in the most recent edition of the *International Classification of Diseases* as a mental disorder. Not included in this definition are conditions or diseases specifically excluded from coverage.

mid-year election change event — An event that allows a primary covered member to make certain changes to their health care coverage. Refer to the Pre-Tax Premium Plan booklet.

morbid obesity — A condition in which an adult has been 100 pounds over normal weight (by the claims administrator's underwriting standards) for at least five years despite documented unsuccessful attempts to reduce under a physician-monitored diet

Network Gap Exception — If there are no in-network providers in the required specialty within a 30-mile radius from the member's home, UHC will grant an exception to allow in-network benefits for services provided by an out-of-network provider.

nonsurgical spinal treatment	Detection or nonsurgical correction (by manual or mechanical means) of a condition of the vertebral column, including • distortion • misalignment • subluxation to relieve the effects of nerve interference that results from or relates to such conditions of the vertebral column
open enrollment	The period of time every year when you have the option to change your medical coverage for the subsequent calendar year (normally held in the fall of each year)
out-of-area plan	Members who do not have access to UHC network providers within a 30-mile radius of their home will be covered under the in-network level of benefits under the out-of-area plan when they access providers. UHC determines who will be placed in the out-of-area plan. Reimbursement is based on billed charges.
out-of-pocket maximum	The member's financial responsibility for covered medical expenses before the Plan reimburses additional covered charges at 100 percent for the remaining portion of that calendar year
outpatient	A person who visits a clinic, emergency room, or health facility and receives health care without being admitted as an overnight patient (under 24-hour stay)
outpatient surgery	Any invasive procedure performed in a hospital or surgical center setting when a patient is confined for a stay of less than 24 consecutive hours
partial hospitalization (or day hospitalization)	A program that provides covered services to persons who are receiving professionally directed evaluation or treatment and who spend only part of a 24-hour period (but at least four hours per day) or 20 hours per week in a hospital or treatment center
participating provider	The health care professionals, hospitals, facilities, institutions, agencies, and practitioners with whom UHC and/or UBH contract to provide covered services and supplies to UHC Standard PPO members

physician	Any individual who is practicing medicine within the scope of his or her license and who is licensed to prescribe drugs. The individual must also be acting within the scope of his/her license and performing a service that is payable under this Plan. A physician eligible for reimbursement by this Plan does not include a person who lives with you or is part of your family (you, your spouse; or a child, brother, sister, or parent of you or your spouse).
plan administrator	Sandia National Laboratories
post-secondary educational program	Students who are classified as graduate, professional, administrative or co-op, graduate engineering minorities, undergraduate co-op, general clerical, technical or business, and general laborer
precertification	The process whereby the member calls UBH to obtain prior approval for certain behavioral health services and EAP benefits
Preferred Provider Organization (PPO)	A network of physicians and other health care providers who are under contract with UHC and/or UBH to provide services for a negotiated fee.
Pre-tax Premium Plan	A plan that allows employees to pay for premiums on a pre-tax basis
primary covered member	The person for whom the coverage is issued, that is, the Sandia employee, retiree, long-term disability terminee, survivor, or the individual who is purchasing temporary continued coverage
primary plan	The Plan that has the legal obligation to pay first when more than one health care plan is involved.
prior notification	The process whereby the member calls UHC to obtain prior approval for certain medical services.
qualified beneficiary	An employee, spouse, or dependent covered the day before the qualifying event, to include a child who is born to or placed for adoption with the covered employee during COBRA. Qualified beneficiaries must be given the same rights as similarly situated employees/beneficiaries.
Qualified Medical Child Support Order	A court-ordered judgment, decree, order, or property settlement agreement in connection with state domestic relation law that either (1) creates or extends the rights of an alternate payee/recipient (see definition) to receive the reimbursement from the Plan or (2) enforces certain laws relating to medical child support

reconstructive procedure	A procedure performed to address a physical impairment where the expected outcome is restored or improved function. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a reconstructive procedure.
reliable evidence	Any published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, treatment, or procedure; or the written, informed consent used by the treating facility or by another facility studying substantially the same drug, device, treatment, or procedure
residential treatment facility	A residential treatment facility provides acute overnight services for the care of a substance abuse disorder or overnight mental health services for members who do not require acute care
Sandia-sponsored medical plans	For employees: UHC Premier PPO, CIGNA Premier PPO, UHC Standard PPO, CIGNA In-Network Plan, and Kaiser HMO (CA only) For non-Medicare members: UHC Premier PPO, CIGNA Premier PPO, UHC High Deductible Health Plan, CIGNA In-Network Plan, and Kaiser HMO (CA only) For Medicare primary members: UHC Senior Premier PPO, CIGNA Senior Premier PPO, Presbyterian MediCare PPO (NM only), Lovelace Senior Plan (NM only); Kaiser Senior Advantage Plan (CA only).
service area	The geographical area, approved by the appropriate staff agency, within which participating providers are accessible to members
sickness	A disease, disorder, or condition that requires treatment by a physician. For a female member, sickness includes childbirth or pregnancy. The term sickness as used in this SPD does not include mental illness or substance abuse, regardless of the cause or origin of the mental illness or substance abuse.
skilled nursing facility	A nursing facility that is licensed and operated as required by law. A skilled nursing facility that is part of a hospital is considered a skilled nursing facility for purposes of the Plan.

sound natural teeth

Teeth that

- are whole or properly restored
- are without impairment or periodontal disease
- are not in need of the treatment provided for reasons other than dental injury

specialist

Any physician who is devoted to a medical specialty

subrogation

The Plan's or claims administrator's right to recover any UHC Standard PPO payments made because of sickness or injury to you or your dependent caused by a third party's wrongful act or for negligence and for which you or your dependent have a right of action or later recovered said payments from the third party

substance abuse

Abuse by the individual of drugs, alcohol, or other chemicals to the point of addiction, which has been diagnosed as an illness by a licensed physician (this is part of the behavioral health benefit) (see also mental or nervous disorder)

total disability or totally disabled

Because of an injury or sickness

- you are completely and continuously unable to perform the material and substantial duties of your regular occupation and are not engaging in any work or occupation for wages or profit
- your dependent is
  - either physically or mentally unable to perform all of the usual and customary duties and activities (the "normal activities" of a person of the same age and sex who is in good health)
  - not engaged in any work or occupation for wages or profit

unproven services

Health services that, according to prevailing medical research, do not have a beneficial effect on health outcomes, and are not based on:

- well-conducted randomized controlled trials
- well-conducted cohort studies

In a randomized controlled trial, two or more treatments are compared to each other, and the patients are not allowed to choose which treatments they receive. In a cohort study, patients who receive study treatment are compared to a group of patients who receive standard therapy. In both cases, the comparison group must be nearly identical to the study treatment group.

If you have a sickness or injury that is likely to cause death within one year of the request for treatment, UHC may, at its discretion, determine that an experimental and investigational service is a covered health service for that sickness or injury. For this to take place, UHC must determine that the procedure or treatment is:

- proved to be safe and promising
- provided in a clinically controlled research setting, and
- using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health

urgent care Medical events that are not life-threatening but require prompt medical attention. Examples of urgent situations are sprains, strains, vomiting, cramps, diarrhea, bumps, bruises, colds, fevers, small lacerations, minor burns, severe stomach pains, swollen glands, rashes, poison ivy, and back pain

urgent care facility Can be attached to a hospital or be freestanding, staffed by licensed physicians and nurses, and providing health care services

urgent care services Treatment of a sudden or severe onset of sickness or injury

Appendix D. 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 are distributed to all new members in the Plan and are distributed to current members under a scheduled time table regulated by ***HIPAA***. In addition, a copy of this notice is available upon request by contacting Sandia ***HBES*** at (505) 844-4237. If you have any questions about the privacy of your health information or you wish to file a complaint under ***HIPAA***, contact the ***HIPAA*** Privacy Officer for Sandia ***HBES***.

Appendix E. UHC Standard PPO Contact Information

Telephone Numbers and Hours of Operation

Function	Telephone Numbers
UnitedHealthcare – www.myuhc.com	
Customer Service • claims questions • check eligibility • benefit information • participating providers • case management	1-877-835-9855 6:00 A.M. – 8:00 P.M. (MST) Monday – Friday
Prior Notification to Care Coordination	1-877-835-9855 6:00 A.M. – 8:00 P.M. (MST) Monday – Friday
Precertification for certain behavioral health services	1-877-835-9855 6:00 A.M. – 8:00 P.M. (MST) Monday – Friday
Precertification for Employee Assistance Program (EAP)	1-866-828-6049 24 hours a day, 7 days a week
Optum NurseLine	1-800-563-0416 24 hours a day, 7 days a week
Onsite Representative (Bldg. 832 east wing)	505-844-0657 Walk-ins/appointments: 9:00 A.M. – 3:00 P.M. (MST) Monday – Thursday Messages recorded after hours, on weekends, and on holidays
Onsite Employee Assistance Program (EAP) New Mexico California	 505-845-8085 925-294-2200
Healthy Pregnancy Program	1-800-411-7984 8:00 A.M. – 10:00 P.M. (MST) Monday – Friday

Function	Telephone Numbers
United Resource Networks (URN) Programs	
• Transplant Resource Services Program	1-877-835-9855
• Cancer Resources Services Program	1-877-835-9855
• Congenital Heart Disease Resource Services Program	1-877-835-9855
• Reproductive Resource Services Program	1-877-835-9855
UnitedHealthcare Allies Health Discount Program	1-800-860-8773 www.unitedhealthallies.com
PharmaCare Prescription Drug Program – www.pharmacare.com	
Customer Service • refill a mail-order prescription • determine if a pharmacy is in the pharmacy network • obtain information about your benefits • speak with a pharmacist about a prescription • request additional ID cards	1-888-249-5041 Monday – Friday 24 hours a day beginning Monday at 5 A.M. (MST) through Friday at 9 P.M. (MST) Saturday 6:00 A.M. – 6:00 P.M. (MST) Sunday 7:00 A.M. – 4:00 P.M. (MST)
Sandia National Laboratories – HBE@sandia.gov	
Benefits Customer Service Center (HBES Customer Service Center), Bldg. 832 east-wing/ Room 34E • enroll/disenroll in health plan • forms, i.e., claims, others • work/family benefits information	505-844-HBES (4237) or 1-800-41SANDI (417-2634) then dial 844-HBES (4237) Fax: 505-844-7535 8:00 A.M. – 4:30 P.M. (MST)
In California, Bldg. 925/Rooms 127, 102	510-294-2254/2073 Fax: 510-294-2392 7:30 A.M. – 4:00 P.M. (PST)

Obtaining Claim Forms/Envelopes

To obtain ***UHC*** Standard ***PPO*** claim forms, PharmaCare Mail Service Prescription Enrollment Order Form/Envelope, or a (***PDP***) Direct Reimbursement Form (Pharma-Care), use any of the following methods:

1. Sandia Line: Dial 845-6789, or if you are calling from outside Albuquerque, dial 1-800-417-2634, then 845-6789. Press “9” for quick dial codes.

- Retirees – press “1088” and “#”. Follow instructions.
- Active Employees – press “1284” and “#” for a fax.

2. Web: Corporate forms www.irn.sandia.gov/corpdata/corpforms/formhp.htm. To retrieve forms, click on Benefits/Lab News from the menu; download the form required; print the form or type in your responses; and print for mailing. The ***PDP*** Direct Reimbursement form is not available on the web.

3. Sandia Benefits department: Sandia ***HBES*** in Albuquerque, Building 832E; Medical Clinic in Livermore

4. Department Secretaries: Secretaries may obtain forms and envelopes from Just-in-Time.

5. Obtain forms from the appropriate administrator, i.e., ***UHC***, PharmaCare.

Sandia Addresses

New Mexico
Benefits
Department 3332, MS 1022
PO Box 5800
Albuquerque, NM 87185

California
Personnel & Employee Resources
Department 8522, MS 9111
PO Box 969
Livermore, CA 94551-9111