Sandia National Laboratories
A Department of Energy National Laboratory

Vision Care Plan

VCP

Summary Plan Description

Effective: January 1, 2002

SAND 2004-2783 W

Vision Care Plan

The Vision Care Plan (VCP) provided by Sandia National Laboratories encourages regular eye examinations by paying part of the cost. It also pays part of the cost for needed corrective lenses and frames.

This booklet is the Summary Plan Description and is provided in accordance with the requirements of the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code. This Summary Plan Description summarizes operations, benefits, claim filing procedures, and other provisions of interest. More detailed information is contained in the official Vision Care Plan documents, which govern the operation of the Vision Care Plan. Copies of these documents are available from the Sandia Benefits Office.

The Vision Care Plan is maintained at the discretion of Sandia and is not intended to create a contract of employment. The Sandia Board of Directors (or designated representative) reserves the right to change, modify, or discontinue the Vision Care Plan at any time without prior notice, subject to applicable collective bargaining agreements.

Contents

Highlights

Summary of Plan Changes

This section contains a brief description of changes that have been implemented since the previous Vision Care Plan (VCP) booklet of January 1, 2000. File this booklet in your *Sandia Employee Benefits Binder* and discard all previous publications.

- SPA Employees no longer have a six-month waiting period for eligibility to participate in the VCP. Eligible employees are eligible to begin participation in the plan from the covered participant's date of hire.
- The frequency for eyeglass lenses and contact lenses changed from once every 24 months to once every 12 months.

  Note: This change does not apply to MTC- and OPEIU-represented employees unless collectively bargained.
- The Additional Benefits schedule services and rates changed. See page 13.
- Eligibility requirement for an unmarried child age 19 to 24 will change from "financially dependent on the covered participant and who is a full-time student attending an institution of learning" to "financially dependent" only.

  Note: This change does not apply to MTC- and OPEIU-represented employees unless collectively bargained.

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Basic Provisions

Purpose of the Vision Care Plan (VCP)

The VCP is designed to

- Encourage regular eye examinations
- Help pay for needed eyeglass frames and corrective lenses
- Offset the cost of additional eyewear purchased through a network (participating) provider.

Who Pays for the Cost of VCP?

Sandia pays the entire cost of the VCP in full for eligible participants **except** for the following groups of eligible participants who pay for part or all of their coverage:

- Part-time employees who are scheduled to work less than 25 hours per week. Premiums can be made on a pre-tax basis through the Pre-Tax Premium Plan.
- Individuals (other than those in the first six months of Child Care or Family Care leaves of absence) who temporarily continue their coverage (see page 32).

Tip

Questions regarding the Pre-Tax Premium Plan can be directed to the Sandia Benefits Customer Service Center (BCSC), 845-2363.

When and What the VCP Pays

Benefits available through the VCP depend on the covered participant's choice of provider.

- If a covered participant accesses a Superior Vision Plan Network (participating) provider, copayments are made to the provider (see page 11).
- If a covered participant accesses a non-network (nonparticipating) provider, the Claim Administrator pays a preset amount based on a schedule specified by the VCP for vision expenses (see page 12).

  These copayments or amounts are payable once in any

  – 12-month period for refractive vision examinations

  – 12-month period for lenses (eyeglasses **or** contact lenses).*

  – 24-month period for frames.

* MTC- and OPEIU-represented employees and their eligible dependents are eligible for lens benefit once every 24 months.

Choice of Providers

Network Option

Covered participants have access to more than 18,000 participating providers nationwide. Network (participating) providers include ophthalmologists, licensed optometrists, independent opticians, and national and regional optical chains.

Non-network Option

Covered participants have a free choice of ophthalmologists, licensed optometrists, and providers of prescription lenses and frames under the non-network option.

Deductible Amounts

There are no deductible amounts under the VCP.

For in-network providers near you, call Member Services at 1-800-507-3800, Weekdays 7 a.m. to 8 p.m. CST, Saturdays 10 a.m. to 3 p.m. CST. Or www.superiorvision.com

Eligibility

Employees

An employee is eligible to participate in the VCP if the employee is

- A regular full- or part-time Sandia employee (as classified by Sandia for payroll purposes), a full- or part-time Limited Term Employee, Postdoctoral Appointee, or full-time/year-round Faculty Sabbatical Appointee* and/or
- An employee on an approved Child Care, Family Care or Military leave of absence.

  Note – Sandia pays the employer portion of the premium for the VCP for the first six months for employees on Child Care, Family Care and Military leaves. For active employees, see detailed information in the *Sandia Employee Benefits Binder* under Family and Medical Leave Act.

- An employee is also eligible to participate if that covered participant elects and pays for temporary continued coverage, as described on page 32.

Tip

Employees who remain on Child Care, Family Care or Military LOA beyond six months must pay the full premium to continue their vision benefit coverage. See page 33 for details.

For purposes of coverage under this Plan, except for the employees identified immediately below, an individual is a covered "employee" only if

- The individual satisfies all other tests for coverage under this Plan
- Sandia Corporation actually withholds required federal, state, or FICA taxes from the employee's paycheck
- Sandia Corporation issues the employee a W-2 for the year in which a vision service and/or materials are provided under the Plan
- Sandia Corporation issues the above W-2 no later than the year following the year in which the vision service and/or materials were provided.

An employee who is receiving benefits under Sandia Corporation's Job-Incurred Accident Disability Plan, who otherwise satisfies the eligibility requirements of this Plan, is a covered "employee" for purposes of coverage under this Plan.

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* Full-time/year-round Faculty Appointee is eligible only if not eligible for other group health coverage.

An employee who is on inactive status because of being on a Sandia Corporation-approved leave of absence, as evidenced by the written approval required for such leave, who otherwise satisfies the eligibility requirements of this Plan, is a covered "employee" for purposes of coverage under this Plan.

Retired employees are NOT eligible.

EXCEPTION – Some retirees who retired on or after January 1, 1987, may be eligible under temporary continued coverage provisions (see page 32).

Eligible Dependents

Dependents who are eligible to participate in the VCP are dependents of a covered employee. As a covered employee, eligible dependents are the covered employee's

- Spouse, not legally separated or divorced from the covered employee.
- Unmarried child under age 19 (see Definitions section, page 40).
- Unmarried child age 19 or over, but under age 24, who is financially dependent on the covered participant.
- For MTC- and OPEIU-represented employees, unmarried child age 19 or over but under age 24 who is financially dependent on the covered participant **and who is a full-time student attending an institution of learning (school).**

Enrollment forms on the Sandia Corporate Forms Web page or Benefits Customer Service Center.

Note – If the child ceases to attend school as a full-time student (because of graduation, reduction in course load, or leaving school for reasons other than illness or injury), coverage under the VCP terminates at the end of the month in which the child ceases to be a full-time student. See Temporary Continued Coverage (COBRA) for Terminees, Surviving Spouse, and Dependents, page 32.

See Definitions section beginning on page 40 for "full-time attendance" and "institution of learning."

- Unmarried child of any age who, because of a physical or mental impairment, including mental illness, meets all of the following criteria:
  - is incapable of self-sustaining employment
  - lives with the covered participant, or in an institution
  - is financially dependent on the covered participant.
- Any child of a covered participant (as defined by ERISA) who is recognized as an alternate recipient in a Qualified Medical Child Support Order (QMCSO). See page 8 for further details on QMCSO.

IMPORTANT **The covered participant must enroll his or her dependent for this coverage as soon as that dependent becomes eligible.**

No Coverage As Both Employee and Dependent

A covered participant cannot be covered as both a dependent and a Sandia employee, or as a dependent of more than one Sandia employee.

Effective Date of Coverage

Coverage becomes effective as follows:

- For employees, coverage starts on the date of hire with Sandia. Eligible participants sign an enrollment form (included in the New Hire enrollment binder) for coverage.
- For dependents, coverage starts on the later of the following:
  - The same day that the employee's coverage starts, or
  - The date a dependent initially becomes eligible if timely enrollment is made as described below.

Changes in Dependent Eligibility

Notify the Sandia Benefits Office in writing of the following changes in dependent eligibility:

- Newly acquired dependents
- A child age 19 or over, who becomes eligible because of a physical or mental impairment, as previously described above.
- Dependents who become ineligible for coverage. See Continuation and Conversion on page 31.

Note –Sandia requires that all changes to VCP enrollment must be processed through the Sandia Benefits Customer Service Center (BCSC), 845-2363, within 31 days of plan eligibility/ineligibility.

Late Enrollees and Special Enrollment Periods

If an eligible participant, including eligible dependents, declines enrollment in the VCP because of other health insurance coverage, that eligible participant may in the future be able to enroll in the Plan after the other coverage ends, provided that a request for enrollment is made to the Sandia Benefits Office within 31 days. In

addition, if an eligible participant acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, the dependent may be enrolled in the VCP, provided that enrollment is requested within 31 days after the marriage, birth, adoption, or placement for adoption.

Qualified Medical Child Support Order

Generally, your Plan benefits may not be assigned or alienated. However, an exception applies in the case of a qualified medical child support order (QMCSO). This Plan will comply with the terms of a QMCSO. A QMCSO is an order or judgment from a court or administrative body directing the Plan to cover a child of a covered participant under a group health plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected insured person and each child (or the child's representative) who is covered by the order will be given notice of the receipt of the order and a copy of the Plan's procedure for determining if the order is valid. Coverage under the Plan pursuant to a QMCSO will not become effective until the Plan Administrator determines that the order is a QMCSO. If you have any questions or would like to receive a copy of the written procedure for determining whether a QMCSO is valid, please contact the Sandia BCSC at 505-845-BENE (2363).

Questions

Contact the Sandia Benefits Office (see Customer Service, page 37) if you have any questions about eligibility.

Appeal Procedures

If Superior Vision Services denies you or a dependent's claim because of **eligibility**, you may contact the Sandia BCSC at 845-2363 to request a review of eligibility status. Written notification will be sent to you of the decision within 72 hours of your request. If you are not satisfied with the decision, you may request that you or your dependent's eligibility status be reviewed by the Employee Benefits Committee (EBC), which you must do in writing within 180 calendar days of the date of the letter informing you of the decision. The EBC has the exclusive right to interpret and apply the eligibility provisions of the Sandia VCP, to construe its terms, and to determine member eligibility thereunder; however, the determination of an incapacitated dependent for the purpose of determining eligibility under the Plan is the responsibility of Sandia's medical carrier (if the medical carrier states the dependent is incapacitated, the dependent is automatically eligible for the Vision Care Plan). The determination of the EBC is conclusive and binding. You will be informed of the EBC's decision in writing within 60 calendar days of the date the appeal was received; however, the EBC can request an additional 60 calendar days if

special circumstances apply. You must exhaust the appeals process before you take legal action against Sandia.

If Superior Vision Services has denied a covered participant's claim based on plan coverage, that person has the right to request that Superior Vision Services reconsider its decision. The procedure for appealing to Superior Vision Services is outlined in Appeals, page 26.

If a claim has been denied because of...	then...
eligibility	contact the BCSC.
benefits administration or any other reason	contact Superior Vision Services.

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Coverage

The VCP provides benefits for covered participants on a scheduled basis, with Plan reimbursement available once every 12 months for refractive eye exam benefits, once every 12 months* for lens benefits, and once every 24 months for frame benefits. Benefits vary depending on the covered participant's choice of a network (participating) provider **or** non-network (nonparticipating) provider as described in this section.

Types of Expenses and VCP Benefit

Network (Participating) Providers

As specified under the VCP, a covered participant's cost or copayment for specific vision care expenses are as follows:

BENEFIT	COVERED PARTICIPANT PAYS
Refractive vision exams**	$20
Frames — up to $90	Any amount over $90
Prescription Lenses (pair; uncoated plastic)	
Single vision	$25
Bifocals	$25
Trifocals	$25
Lenticular	$25
Contact lenses — Up to $100	Any amount over $100

Additional purchases are available to covered participants at significant discounts. Please see page 13 for additional benefits offered by network (participating) providers.

* MTC- and OPEIU-represented employees and their eligible dependents are eligible for lens benefit once every 24 months.

** Contact lens exams require additional fees. These fees are separate from the refractive vision exam and will vary from provider to provider. The contact lens exam/fitting fees may be included in the contact lens allowance.

Non-network (Nonparticipating) Providers

As specified under the VCP, the Claim Administrator pays a fixed amount for specific vision care expenses. The type of expenses and the maximum fixed amounts are shown below:

BENEFIT	PLAN PAYS
Refractive vision exam	$30
Prescription lenses (pair)	
Eyeglass lenses	
– Single vision	$30
– Bifocals	$50
– Trifocals	$60
– Lenticular	$80
Contact lenses	$80
Disposable contact lenses (one supply)	$80
Eyeglass frame	$40

IMPORTANT **If the covered charge is less than the scheduled amount, the maximum the VCP pays is the covered charge.**

Refractive Vision Exams Not Covered for Kaiser HMO Participants

Kaiser Permanente HMO Plan provides refractive vision exams to enrolled participants at the current Kaiser copayment. Therefore, VCP benefits for refractive vision exams are **not** provided for employees or their dependents enrolled in the Kaiser HMO. The VCP will not reimburse any portion of the applicable Kaiser copayment.

Frequency Limits

As specified under the VCP, the Claim Administrator, Superior Vision Services, reimburses vision care expenses for network and/or non-network providers on the following frequency schedule:

- **Refractive vision exams** — one exam in any 12 months (from the last claim paid).
- **Lenses** — one pair of eyeglass lenses, **or** one pair of contact lenses, **or** one supply of disposable contact lenses in any 12 months (from the last claim paid).

  Note: MTC- and OPEIU-represented employees and their eligible dependents are eligible for the lens benefit once every 24 months (from the last claim paid).

- **Frames** — one frame in any 24 months (from the last claim paid). Frames must be fitted and used with prescription lenses.

When Expenses Are Incurred

Expenses for any service or supply are considered incurred as follows:

- **For refractive vision exams** — on the date of the exam.
- **For lenses or frames** — on the date they are ordered by the covered participant.

See pages 14 and 15 for examples.

Additional Benefits Offered

The Materials Discount Plan Benefit: Discounts apply to the purchase of additional pairs of eyeglasses and contact lenses, not toward the covered benefit. The discount benefit is available **only** from Superior Vision Services **in-network** providers who are identified in the provider directory with a "**DP**." The discount does not apply to the covered benefit.

Prescription eyeglass lenses	30% off retail prices
Add-on charges to basic lenses	20% off retail prices
Contact lenses, standard hard or soft	20% off retail prices
All other prescription materials	20% off retail prices
Eyeframes	30% off retail prices
Everyday "frame and lens package pricing"	20% off retail prices
Disposable contact lenses	10% off retail prices

Refractive Surgery Discount Plan Benefit: Superior Vision Services has contracted a network of more than 450 refractive surgeons nationwide who specialize in the popular elective procedures of radial keratotomy (RK), photo-refractive keratotomy (PRK) and LASIK. These providers offer Superior Vision Plan members a 20% discount off their usual and customary surgical fees for these procedures.

Cosmetic Eyelid Surgery Discount Plan Benefit: Ophthalmic plastic surgeons are also contracted to provide the procedure of blepharoplasty (cosmetic eyelid surgery) to Superior Vision Plan members. These providers offer Superior Vision Plan members a 20% discount off their usual and customary surgical fees for this procedure.

Examples of Covered Expenses

Example 1

A covered participant had a refractive vision exam on February 10, 2001, and ordered a pair of single-vision prescription eyeglasses and an $80 frame on March 5, 2001. The covered participant had made no previous claims under the VCP.

- Network (participating) provider
  - The covered participant made the following copayments to the provider:
    - $20 for the exam
    - $25 for a pair of single vision lenses
    - $0 for the frame (frame was within plan allowance of $90)
  - The VCP paid the network (participating) provider in this example for the full cost of the frame and expenses incurred above the covered participant's copayment amounts.

- Non-network (nonparticipating) provider
  - The covered participant filed a claim, and the VCP reimbursed the covered participant up to the following amounts under the schedule:
    - $30 for the exam
    - $30 for a pair of single vision lenses
    - $40 for an eyeglass frame
  - The covered participant was responsible for any amount charged in excess of the VCP benefit.

The covered participant became eligible for a covered eye exam on February 1, 2002 and is eligible for covered lenses, if needed, on March 1, 2002. The covered participant would be eligible for a covered frame on March 1, 2003.

Note: If the covered participant is an MTC- or OPEIU-represented employee or an eligible dependent of an MTC- or OPEIU-represented employee in this example, the covered participant would again be eligible for covered lenses on March 1, 2003.

Example 2

A covered participant lost one prescription contact lens and ordered a replacement from the provider on April 9, 2001. The charge for this replacement contact lens was $40 and the covered participant had made no previous claims under the VCP.

- Network (participating) provider
  - The VCP allows for a contact lens allowance of $100 per pair.
  - The covered participant was not responsible for any copayment.
  - The network (participating) provider filed a claim to the Claim Administrator for the contact lens benefit.
- Non-network (nonparticipating) provider
  - The covered participant must pay the non-network (nonparticipating) provider the full cost of the contact lens.
  - The covered participant filed a claim and the VCP paid the $40 charge.

Since the VCP pays for prescription contact lenses once in a 12-month period, this $40 claim will be paid in full under the provisions of the VCP. With this payment, the covered participant has used up the benefit for lenses in that 12-month period. The remaining amount is **not** available for additional expense reimbursement.

The covered participant would be once again eligible for covered lenses on April 1, 2002.

Note: If the covered participant is an MTC- or OPEIU-represented employee or an eligible dependent of an MTC- or OPEIU-represented employee in this example, the covered participant would again be eligible for covered lenses on April 1, 2003.

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Exclusions

What the VCP Does Not Cover

As with all group benefit plans of this type, this VCP does not cover certain expenses. The following list itemizes most exclusions, but it is not all-inclusive.

The VCP does not cover care under other benefit plans, such as those of:

- The armed forces of any government,
- Any civil unit of any government,
- Workers' Compensation or similar law, or
- Any other benefit plan of Sandia.

Note – Because Kaiser Foundation Health Plan pays for refractive vision exams at no additional cost to Kaiser participants, VCP benefits for refractive vision exams are not provided for employees/dependents enrolled in the Kaiser Foundation Health Plan.

The VCP also excludes refractive vision examinations performed and lenses and frames ordered

- **Before** the individual became eligible for coverage under the VCP, or
- **After** termination of the individual's coverage.

Refractive vision exams performed **within** the 12 months following the last incurred date for services through a network (participating) and/or non-network (nonparticipating) provider.

Lenses ordered within the 12 months following the last incurred date for lenses through a network (participating) and/or non-network (non-participating) provider.

Frames ordered within the 24 months following the last incurred date for frames through a network (participating) and/or non-network (non-participating) provider.

Tip

Some services and/or products may be purchased at any time at a discount from a network (participating) provider. See page 13 for the discount listing.

Tip

Prescription drugs may be covered under the Sandia Prescription Drug Program under the Sandia Top PPO Plan, Sandia Intermediate PPO Plan, Sandia Basic PPO Plan, Sandia/Cigna Network POS Plan or the Kaiser Permanente HMO Plan.

Charges for:

- Drugs or other medications;
- Experimental services or supplies;
- Extra charges for tinted, oversized, photosensitive, or antireflective lenses, whether or not medically necessary;
- Lenses that do **not** require a prescription;
- Lens-care kits, cleaning solutions, lens insurance, and extra fittings;
- Progressive lenses;
- Replacement of broken or lost lenses if a lens/lenses were previously obtained within the preceding 12-month period;
- Services or supplies that are:
  - not prescribed by a licensed physician, optometrist, or ophthalmologist;
  - otherwise free of charge to patients.

Treatments including (but not limited to)

- Special or unusual treatment such as
  - Orthoptics,
  - Vision training,
  - Subnormal vision aids,
  - Aniseikonic lenses,
  - Tonography;
- Medical or surgical treatments [see the Sandia Top PPO Plan, Sandia Intermediate PPO Plan, Sandia Basic PPO Plan, Sandia/Cigna Network POS Plan or the Kaiser Permanente HMO Plan for possible reimbursement of these types of expenses];
- Refractive vision exams or materials furnished for any condition, disease, ailment, or injury arising out of or in the course of employment or covered by Workers' Compensation payments.

Accessing Care

When a covered participant needs an eye examination, glasses, or contact lenses, that covered participant has the option of accessing care through either a Network (participating) provider or a non-network (nonparticipating) provider as detailed below.

Network (Participating) Providers

- Simply go to a participating optical department and identify yourself as a Sandia Vision Care Plan participant.
- Using the employee's social security number, the optical outlet will verify eligibility, the exact plan of benefits and any fees that apply.

It's as simple as that...no claim forms to fill out...no waiting for reimbursement.

For more information, call

Superior Vision Services Member Services at

1-800-507-3800.

Tip

You are encouraged to call the provider in advance of your visit to identify yourself, make an appointment, and verify your eligibility.

Non-network (Nonparticipating) Providers

- A covered participant can access care from any licensed provider.
- The covered participant will be responsible for payment at the time expenses are incurred.

Obtain a claim form from the Sandia Corporate Forms Web page or call the Sandia BCSC at 845-2363. Submit your completed claim form to Superior Vision Services to receive reimbursement. (See Filing Your Claims, beginning on page 23, for information on submitting claims.)

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Coordination of Benefits

Overview

This section defines and explains Plan provisions designed to eliminate duplicate payments and provides 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.

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

The rules of the National Association of Insurance Commissioners (NAIC) for the Coordination of Benefits (COB) state that the COB

- Applies only to group plans, **not** to individual insurance,
- Does **not** apply when married persons are both members in Sandia's plans, and
- Follows the birthday rule (see item 3 in the table on the following page).

Use the table on the following page to determine

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

	If...	then...
1	the other plan (including HMOs) does not have a COB provision,	the plan with no COB provision is primary.
2	both plans have COB provisions,	the plan covering the person as an employee is primary and will pay benefits up to the limits of that plan. The plan covering the person as a dependent is secondary and pays the remaining costs to the extent of coverage.
3	both plans have COB provisions and use the birthday rule for dependent children coverage,	the plan covering the parent whose birthday comes first (month and day) in the year is the primary plan and will pay benefits first. The plan covering the other parent is secondary and pays the remaining costs to the extent of coverage.
4	both plans have COB but do not use the birthday rule,	the male-female rule applies. The rule says that the father's group insurance is the primary plan and will pay the benefits first. The mother's group insurance is secondary and pays the remaining costs to the extent of her coverage.
5	both plans have COB but one parent is covered by the male-female rule and the other by the birthday rule,	the male-female rule applies. The rule says that the father's group insurance is the primary plan and will pay the benefits first. The mother's group insurance is secondary and pays the remaining costs to the extent of her coverage.
6	a divorce or legal decree establishes financial responsibility for health care for the dependent,	the parent who has that responsibility will be the holder of the primary plan.
7	a divorce decree does not establish financial responsibility for health care of the dependent,	the plan of the parent with custody is the primary plan. The other parent's plan is secondary.
8	a divorce decree does not establish financial responsibility and assigns joint custody,	each parent is primary when the child is living in that parent's home.
9	a divorce decree does not establish financial responsibility, and the parent with custody remarries,	the custodial parent's plan remains primary; the stepparent's plan is secondary. The non-custodial parent's plan is third.
10	payment responsibilities are still undetermined,	the plan that has covered the patient for the longest time is the primary plan.

Filing Your Claims

Benefits under this VCP are administered in accordance with the contract between Sandia and the Claim Administrator, Superior Vision Services. The procedure for claims processing varies based on care received either by a network (participating) provider or a non-network (nonparticipating) provider as detailed below.

Network (Participating) Provider Procedure

- Obtain care and/or services from a network (participating) provider.
- The covered participant pays the applicable copay amount and any costs that are above and beyond the VCP provisions.
- The provider files claims for services and materials.

Non-network (Nonparticipating) Provider Procedure

- Call Superior Vision Services Member Services Department at

  1-800-507-3800 to receive an authorization number.*
- Obtain care from any licensed provider.
- The covered participant pays for incurred expenses.
- Obtain a claim form by accessing the Sandia Corporate Forms Web page or by calling the Sandia BCSC at 845-2363.
- See the remainder of this section for further instructions.

Where to Obtain Claim Forms

Claim forms for VCP participants can be obtained from the Sandia Corporate Forms Web page, or from the Sandia BCSC, 845-2363, or by requesting a faxed copy from

* This step is recommended in order for you to verify your eligibility, obtain Plan information, and nominate providers if desired. If you choose to skip this step, your claim will still be processed and paid unless you are not eligible for benefits.

Sandia Line (845-6789, dial 9, enter 1284#. If out of Albuquerque, call 1-800-417-2634 first).

When to Submit Claims

Tip

Whenever possible, submit all claims to the Claim Administrator within 90 days.

Submit a written notice of the claim (preferably using the claim form) to the Claim Administrator:

- After the vision expenses are incurred, or
- After the end of the calendar year.

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

CAUTION – The VCP will not cover claims submitted more than one year after the date of service.

How to Complete the Claim Form

The instructions for completing a claim form for non-network (nonparticipating) provider benefits will vary depending on how the employee accesses a claim form. While some of these instructions may not apply, the full data requirements are listed below:

- Patient Information:
  - Employee (insured) name,
  - Name of person receiving services,
  - Employee (insured) social security number,
  - Employee address, city, state, and ZIP code,
  - Date of birth of person receiving services,
  - Patient relationship to employee (member),
  - Patient signature,
  - Today's date,
  - Authorization number.*
- Exam
  - Request that the provider complete this section, or
  - Attach an original itemized copy of the billing received from the non-network provider.

* If you did not receive an authorization number, leave this space blank.

Mailing the Claim Form

Mail the claim form along with copies of any bills to the address of the Claim Administrator (shown on the claim form), as follows:

Superior Vision Services
P.O. Box 308
Rancho Cordova, CA 95741

How Benefits Are Paid

Benefits under the VCP will be paid as follows:

Network (Participating) Provider Benefits

- The covered participant will pay the applicable copayments for exams and lenses to the network (participating) provider at the time services are rendered and/or materials are ordered. The provider will then submit the remainder of the cost to Sandia, which will in turn pay the provider.
- An established eyeglass frame allowance will be paid to the provider upon submittal of a **provider** claim. Any amount above and beyond the established eyeglass frame allowance must be paid in full by the covered participant.
- An established contact allowance will be paid to the provider upon submittal of a **provider** claim. Any amount above and beyond the established contact allowance must be paid in full by the covered participant.

Non-network (Nonparticipating) Provider

- The covered participant will be required to pay for incurred expenses for services from a licensed provider.
- Call the Sandia BCSC to receive a claim form, or access the Sandia Corporate Forms Web page.
- The VCP Claims Administrator will reimburse the covered participant for covered services determined by the schedule outlined on page 12.

Right to Recover Excess Payments

The Claim Administrator has the right at any time to recover any amount paid by the VCP for covered charges in excess of the amount that should have been paid under the VCP provisions.

Payments may be recovered from the covered participant, providers of service, and other group benefit plans.

By accepting benefits under the VCP, the covered participant agrees to repay or, as appropriate, cooperate in recovery of excess payments.

Questions

If a covered participant has not been notified about a claim within 60 days of filing, contact the Claim Administrator, Superior Vision Services. (Refer to Superior Vision Services, Administrative Services, page 37.)

Appeals

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

Policy

A covered participant or another duly authorized person may appeal a denial or other action **if**

- A claim for benefits is denied, and
- A covered participant feels that he or she has been treated unfairly with respect to any of the Plans.

Written Notice of Claims Denial

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

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

Time Limit for Filing an Appeal

The covered participant or another duly authorized person may appeal the denial of claims or any other action in writing **within 60 days** after receipt of notification of the Claim Administrator's decision. Send written request for review of any denied claim or other disputed matter directly to the Claim Administrator at

Superior Vision Services
P.O Box 308
Rancho Cordova, CA 95741

In any case, as a covered participant in this VCP, additional rights may be available under the Employee Retirement Income Security Act of 1974. This information, as well as certain general information concerning the VCP, is included in the *Sandia Employee Benefits Binder* as a separate booklet called "ERISA Information."

IMPORTANT **Superior Vision Services has the exclusive right to interpret and apply the provisions of the VCP, and the benefit claim decision is conclusive and binding. VCP provisions require that a covered participant pursue all claim and appeal rights described above before seeking any other legal recourse regarding claims for benefits.**

Procedure to Appeal Claims Denial

The following is the procedure for appealing denial of claims.

Step	Who	Action
1	**Covered participant or authorized representative**	Submit letter to the Claims Administrator within 60 days after receipt of the denial ■ A request for reconsideration (appeal). ■ Documents or records in support of the appeal.

Step	Who	Action
		NOTE — The covered participant and his or her representative are entitled to review related documents.
2	**Claim Administrator**	Notify the covered participant of the decision on the appeal within 60 days.
3	**Claim Administrator**	If a decision on the appeal is not made within 60 days, and if special circumstances require an extension of time to make a decision on the appeal, ■ Notify the covered participant that an additional 60 days are required for the review; ■ Notify the covered participant in writing of the decision on the appeal within 120 days.

When Coverage Ends

Employees

Except as provided under Continuation and Conversion (see page 31), coverage under the VCP stops on the

- Last day of the month that the employee is no longer eligible, e.g., because of termination of employment, death, or retirement,
- Date any cost of coverage is not paid when due,
- Date the VCP is terminated.

Dependents

Coverage under the VCP for dependents (including surviving spouses) stops on the

- Last day of the month in which the employee dies or terminates,*
- Last day of the month in which the dependent spouse legally divorces or separates from the employee/retiree,*
- Last day of the month during which a dependent child marries or ceases to be eligible,*
- Date that a dependent child becomes eligible for coverage as an employee under this VCP,
- Date on which any cost of coverage is not paid when due,
- Date that the VCP is terminated.

* In this event, the covered participant may be eligible for temporary continued coverage under COBRA. See Continuation and Conversion, page 31.

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Continuation & Conversion

Introduction

This section explains how benefits are continued

- During leaves of absence,
- For the surviving spouse and dependents,
- For eligible individuals under federal legislation (COBRA).

During Leaves of Absence (LOAs)

LOA for Child Care and Family Care

Sandia will waive the premium for the VCP for the first six months for employees on approved Child Care, Family Care and Military leaves if the employee is eligible for the VCP at the beginning of the leave. Employees remaining on LOA beyond the six months must pay the premium to continue VCP coverage (contact the Sandia BCSC).

All Other LOAs

VCP coverage stops at the end of the month in which the LOA begins. Coverage may be continued at a covered participant's expense until the end of the leave (contact the Sandia BCSC). If a covered participant does not return to work at the end of the LOA, additional coverage may be available under temporary continued coverage (see page 32).

Employees on an LOA are not charged the 2% COBRA administration fee.

Important: Coverage during the LOA runs concurrently with (i.e., applies toward) the temporary continued coverage explained under COBRA, page 32. If you terminate employment at the end of the LOA, additional coverage months may be available under COBRA depending on the number of months taken for the LOA.

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

The federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA), which became effective January 1, 1987, requires Sandia to offer a temporary extension of group health coverage to covered employees and dependents who would lose their group health coverage as the result of certain events (see list on the next page).

The cost for coverage would be at the group rate plus a 2% administrative fee.

Qualified persons for this coverage include

- The primary covered participant (the employee),
- The covered participant's spouse,
- The covered participant's dependent children,

if covered under the VCP on the day before the events causing loss of coverage as described on the following page.

In addition, a qualified beneficiary under COBRA also includes a child born to or placed for adoption with a covered employee during the period of the employee's continuation coverage. Once the newborn or adopted child is enrolled in continuation coverage pursuant to the VCP rules, the child will be treated like all other COBRA qualified beneficiaries.

Certain Events Causing Loss of Coverage

These are the specific events causing loss of coverage for terminees, surviving spouses, and dependents. The length of time for the optional COBRA coverage is noted.

If you are the . . .	and if you, the covered person, lose VCP coverage because of . . .	then, under COBRA, you have the right to choose temporary continued coverage for a maximum of . . .
employee, spouse or a dependent child	■ a reduction in the number of hours of employment at Sandia, ■ termination of employment, including retirement,	18 months.
employee, spouse, or a dependent child	■ termination 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. **Note: After the first 18 months, you will be charged 150% of the cost of the regular premium.**
spouse	■ the death of the Sandia spouse, ■ a divorce or legal separation from your Sandia spouse,	36 months.
dependent	■ the death of a Sandia parent, ■ a divorce or legal separation of your parents, ■ a change in eligible status, i.e., dependent ceases to be a dependent child under the VCP,	36 months.

Election Procedures (COBRA)

This is the procedure to elect temporary continued coverage under COBRA.

Step	Who	Action
1	Employee or family member	Notify Sandia BCSC in writing within 60 days* of ■ divorce, ■ legal separation, ■ loss of a child's dependent status, ■ disability designation by Social Security, ■ death of a primary covered participant other than an employee.
2	Sandia Personnel Department	Inform Sandia BCSC of covered participant's ■ death, ■ termination of employment, ■ reduction in hours.
3	Sandia BCSC	Notify participants that they have the right to choose continued coverage within 60 days from latest of the following dates ■ of notification by Sandia BCSC, ■ coverage actually ends.
4	Covered participant	Contact Sandia BCSC to elect COBRA coverage. ■ Covered participant has 60 days to elect COBRA from the latter of the date of the notice or their loss of coverage date, whichever is later. ■ Covered participant has 45 days from the election date to make first premium payment. ■ **If you elect continued coverage**, then Sandia provides coverage under the VCP **at your expense** plus the applicable administrative fee. **If you do not elect continued coverage,** then group coverage under the VCP ends.

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

Termination of Temporary Coverage

Temporary continued coverage under VCP may be terminated before 18, 29, or 36 months when

- Sandia no longer provides coverage to any employee,
- The premium for continued coverage is not paid,
- The person becomes covered under another group health plan.

Coverage extensions required under other laws (for example, due to state law) continue concurrently with temporary continued coverage.

No Conversion Privileges

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

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Superior Vision Services Administrative Services

Superior Vision Services provides the following administrative services:

- Customer service,
- Panel of network providers,
- Determination of benefits under Sandia's VCP according to the covered participant's choice of provider, and
- Administration of the appeals procedure for claims under the VCP. See page 26 for information on the appeal procedure.

Customer Service

VCP questions may be directed to any of the following customer service numbers:

Superior Vision Services	**1-800-507-3800**
Sandia Benefits Office — Livermore	510-294-2254
Sandia Benefits Office Albuquerque and other remote sites 845-2363	505-845-2363 or 1-800-417-2634, then dial

ERISA Information

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

Plan Information

The Vision Care Plan is a self-insured plan for eligible participants and their dependents (as defined by this booklet) of Sandia National Laboratories, P.O. Box 5800, Albuquerque, NM 87185 (Employer Identification Number 85-0097942).

The Vision Care Plan (PN 519) is administered on a calendar-year basis from January 1 through December 31 for the filing of reports to the Department of Labor. Superior Vision Services is the Claim Administrator for the Vision Care Plan.

For information concerning the service of the legal process, contact the Sandia Legal Division, P.O. Box 5800, MS 0141, Albuquerque, NM 87185.

Acronyms and Definitions

Acronyms

BCSC	Benefits Customer Service Center (Sandia)
COB	coordination of benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
EBC	Employee Benefits Committee
ERISA	Employee Retirement Income and Security Act of 1974
FICA	Federal Insurance Contributions Act
FMLA	Family and Medical Leave Act
HMO	Health Maintenance Organization
LOA	leave of absence
MTC	Metal Trades Council
NAIC	National Association of Insurance Commissioners
OPEIU	Office & Professional Employees International Union
QMCSO	qualified medical child support order (see definition)
SPA	Security Police Association
VCP	Vision Care Plan

Definitions

alternate payee/recipient

A child or custodial parent who is not a primary insured and who, because of a "qualified medical child support order" (see definition), is entitled to receive a reimbursement directly from the Claim Administrator.

bifocal lens

A lens with two different focal lengths. One lens is to adjust the eyes for close focus; the other lens is for distant focus.

child

Under this VCP, a child is defined as

- An adopted child, if the pre-adoption agreement and/or final adoption papers have been completed and submitted to the Sandia Benefits Office.
- A stepchild who lives with the covered participant at least 50% of the year (stepchildren living with you for the summer are not considered to be living with you) or living in a home provided by the covered participant.
- A child of the employee, if a court decree requires the employee to provide coverage.
- A child living with the employee for whom the employee (or employee's spouse) is the legal guardian. (Does not include foster children.)

Claim Administrator

The third party designated by Sandia to verify eligibility for network (participating) providers, and to receive, process, and pay claims to the covered participant when the covered participant accesses non-network (nonparticipating) providers according to the provisions of the VCP.

contact lens

A lens that fits directly on the eyeball to correct refractive errors.

coordination of benefits (COB)

When a covered participant has vision coverage under other vision care plans, VCP payments are reduced so that total combined payments from all plans do not exceed 100% of the highest allowable VCP reimbursement.

covered charge

A vision expense incurred by the covered participant and payable under the terms of the VCP.

covered participant

Regular employees (including part-time employees) and their eligible dependents who have enrolled in the VCP.

financially dependent persons

Persons who receive more than 50% of their support from the primary covered participant.

frame — A support that holds two eyeglass lenses.

full-time attendance — Defined by the school as a set number of hours (usually twelve hours or more for undergraduates and nine hours or more for graduate work) for which the student is registered. Includes normal school vacations such as summer, semester, and holiday breaks.

incur — The date a service is actually performed, or the date a supply or material is actually ordered.

institution of learning — Any accredited high school, college, or university or bona fide educational institution such as a nursing school, trade school, etc., having an established curriculum for students in full-time attendance (see definition above). Correspondence schools, night schools, or schools requiring less than full-time attendance are not acceptable. Apprentice programs are not considered "institutions of learning." Usually the institution has a full-time, regular faculty and presents some evidence of the student's successful completion such as a diploma or certificate.

Note—"School" is referred to for dependents ages 19 through 23; see page 6.

lens — A corrective device made out of either glass or plastic.

lenticular lens — An eyeglass lens for persons who have had cataracts removed surgically.

network (participating) provider — The doctors, opticians and optical department personnel who contract with the Claim Administrator to provide quality care and eyewear.

non-network (nonparticipating) provider — Licensed doctors, opticians, and optical outlets not contracted with the Claim Administrator.

ophthalmologist — A medical doctor who specializes in eye care.

optician — A person legally qualified to supply lenses and frames according to prescriptions written by an ophthalmologist or optometrist.

optometrist — A doctor of optometry trained and legally qualified to perform eye exams and to prescribe lenses.

primary plan — When other health plans are involved, the primary plan is the plan that has the legal obligation to pay first.

qualified medical child support order

A court-ordered judgment, decree, order, or property settlement agreement in connection with state domestic relations 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.

refractive vision exam

Performed by an ophthalmologist or optometrist to check a covered participant's eyes and prescribe treatment if needed. The refractive vision exam includes the following:

- History,
- External examination of the eye,
- Determination of refractive status,
- Binocular measurements,
- Examination of the interior of the eye by instrument,
- The prescribing of lenses, if needed.

Covered services do not normally include dilation and glaucoma testing. However if the Claim Administrator's network providers are contracted to provide these services at no additional charge, these services may be included as part of the exam.

trifocal lens

Like a bifocal lens but has an added narrow area to adjust the eye for intermediate focus.