Sandia National Laboratories

Kaiser Permanente Traditional Plan

Health Maintenance Organization (HMO)

- ***Active Employees***
- ***Retirees: Under 65***

Summary Plan Description

Effective: January 1, 2005

SAND 2004-2783 W

Kaiser Permanente

The Kaiser Health Plan (KHP), a federally qualified health maintenance organization (HMO), provides health care services to its members using doctors and facilities located within a specific geographic area. KHP is the largest HMO in the country.

This booklet is the Summary Plan Description (SPD) that summarizes operations, benefits, and other provisions of interest. More detailed information is contained in the Kaiser Health Plan Disclosure Form booklets and the Kaiser Health Plan Group Agreement. If there is any discrepancy between this SPD and the Kaiser Group Agreement, the language of the Kaiser Health Plan documents shall govern. Copies of these documents are available from your Sandia Corporation Benefits Department.

The Kaiser Health Plan is maintained at the discretion of Sandia. It 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 suspend, change, modify, discontinue, or terminate the Kaiser Plan at any time without prior notice. If the Kaiser Plan should be terminated or changed, it will not affect your right to any benefits to which you have already become entitled.

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APPENDICES

Section 1

How the Plan Works for You

As a member, you are able to choose a primary care physician who is part of a dedicated team of health care specialists, technicians, and nurses. You can also obtain health care advice over the phone 24 hours a day from Kaiser advice nurses. You and your eligible dependents will benefit from one of the largest selections of preventive health care programs and classes available today.

All of the health care services you may need – from routine care with your own primary care physician or specialist to hospitalization, advice nurses, lab and pharmacy services, worldwide emergency benefits, and health education – are provided in the Kaiser Plan.

There are no deductibles and no claim forms to file, and you pay a minimal copayment for most visits. The annual out-of-pocket copay maximum limit is $1,500 for one person and $3,000 for two or more people.

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Section 2

Getting Started

This section outlines basic member information you need to get started using the Kaiser Plan.

Selecting a Physician

You are encouraged to choose a Medical Group physician (adult or internal medicine family practice or pediatrics) as your personal primary care physician who will assist you with all your health care needs, including arranging for hospitalization and referrals to specialists.

You may choose any Kaiser Plan primary care physician who is currently taking new patients. You may also change your physician at any time for any reason simply by scheduling an appointment with a different Kaiser physician. For additional information, see the *Guidebook to Kaiser Permanente Services*.

Your Member ID Card

Upon enrollment, Kaiser will assign to you a unique medical record number referenced on your Kaiser member identification (ID) card.

Your member (ID) card will give you access to Kaiser services. It will be sent to your home after you enroll.

Member Services

If you have questions, call Kaiser Member Services at **800-464-4000** to get help in understanding and using your Health Plan benefits. A Member Services representative is available from 7 a.m. to 7 p.m., seven days a week and will assist you with the following:

- Appointment information,
- Address of the nearest Kaiser location,
- Benefits options upon birth or adoption of a child,
- Obtaining the *Guidebook to Kaiser Permanente Services*,
- Relocation to a new service area when you move to a new address,
- Determining your enrollment or eligibility,
- Checking status or replacing an ID card that is worn or lost, or
- Obtaining a *Travel Guide* information packet.

Telephone Advice Line

You can obtain health care advice by telephone, 24 hours a day, from nurses who work in partnership with a Kaiser medical team. If the advice nurse cannot provide the advice you are seeking over the telephone, the nurse can make an urgent care appointment for you with a physician or nurse practitioner.

Section 3

Eligibility

This section outlines the service area for enrollment purposes as well as the eligibility requirements for active employees (and cost of coverage), retirees, other eligible persons, and dependents. For information on the cost of coverage for retirees and other eligible persons, see Continuation and Conversions, page 11-1. This section also provides information on coverage options that are available when a Sandia employee/retiree is married to another Sandia employee/retiree, information concerning a Qualified Medical Child Support Order (QMCSO), and information about the eligibility appeals process.

NOTE: Eligibility, enrollment, premiums, contributions, or benefits may not be based on an employee's (or dependent's) medical condition, disability, evidence of insurability or other health factors.

Service Area

This Plan is available to employees and non-Medicare-primary retirees, other eligible persons, and their dependents who live in the following counties: Alameda, Contra Costa, Marin, Sacramento, San Francisco, San Joaquin, Solano, and Stanislaus. Portions of other northern California counties are also included and are indicated by specific ZIP codes outlined in the Kaiser Group Agreement definitions section available through California Benefits and Health Services (925-294-2254).

When you change your residence or work site to **outside** of the service area, coverage will be terminated on the day of the change of residence or work site or the date of written notification to the Benefits Department, whichever is later, provided that Sandia Benefits is given written notification with 31 calendar days of the change. You may switch to the Top PPO Plan, the CIGNA POS, the Basic PPO Plan, or the Intermediate PPO Plan, whichever is applicable, or drop coverage altogether. If written notification is not provided to the Sandia Benefits Department within 31 calendar days, you and your covered dependents will not be covered by a Sandia Medical Plan.

If you are enrolled in another plan, and you change your residence or you have a change in your work site to **within** the service area, you may elect to enroll yourself and your covered dependents in the HMO Plan provided that written notification is given to Sandia Benefits within 31 calendar days of the changes in residence or work site. Coverage will be effective on the day of the change in residence and/or change in work site or the date of written notification to the Benefits Department, whichever is later.

Active Employees

You are eligible to participate in this Plan on the day you report for active employment if you live in the Kaiser service area at the time you enroll and you are a

- regular, full- or part-time employee as classified by Sandia for payroll purposes;
- limited-term, full- or part-time employee or postdoctoral appointee;
- faculty sabbatical appointee **not** eligible for other group health care coverage;
- year-round or long-term student employee who is enrolled in a post-secondary program and who is not covered by another medical plan. (See post-secondary education program in Appendix A.)

NOTE: High school student employees are not eligible for the Kaiser Plan.

For purposes of coverage under this Plan, except for the employees identified under Exceptions 1 and 2 below, an individual is a "covered employee" only if

- the individual satisfies all tests for coverage under the Kaiser Plan,
- Sandia Corporation withholds required federal, state, or FICA taxes from his/her paycheck,
- Sandia Corporation issues him/her a W-2 for the year in which a medical service under the Kaiser Plan is provided, and
- Sandia Corporation issues the W-2 no later than the year following the year in which the medical service was provided.

EXCEPTIONS

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

Employee Contributions

Sandia pays the majority of the premium costs except as noted below for the Kaiser Health Plan; however, all enrolled employees pay a monthly cost for coverage in this Plan. Refer to your open enrollment booklet or new hire binder, or call the Benefits Customer Service Center (BCSC) at 845-2363 to find out your monthly cost. The monthly cost-sharing amount is deducted from your bi-weekly paycheck in two equal installments each month. Employees have the opportunity to enroll in the Pre-Tax Premium Plan to pay for these costs on a pre-tax basis upon initial enrollment or during the annual Open Enrollment period. Refer to the Pre-Tax Premium Plan booklet for more information.

NOTE: Part-time employees working less than 23 hours a week pay one-half the full premium cost.

Retirees

You are eligible to participate in this Plan if you

- live in the Kaiser service area at the time you enroll,
- are a retired employee under age 65, and
- are not eligible for Medicare primary coverage.

If you are a retiree age 65 or older and are eligible for Medicare for yourself and/or your dependents, coverage is provided through the Kaiser Senior Advantage Plan (KSAP).

If you are a retiree, you and your dependents must apply for Medicare coverage as soon as you become eligible to avoid any lapse in coverage from the Kaiser Plan to the Kaiser Permanente Senior Advantage Plan (KSAP). See the KSAP SPD for additional details.

IMPORTANT **Retirees who participate in the Kaiser Plan do not participate in another Sandia medical plan. The option to choose participation is available during the annual Open Enrollment period.**

Dual Sandians

If you are a Sandia employee/retiree married to another Sandia employee/retiree, you may elect to cover yourself as

- an individual,
- a dependent of your Sandia spouse, or
- the primary covered member with your Sandia spouse as a dependent.

If the primary member is an employee, cost sharing of monthly contributions is based on the salary tier of the Sandia employee. If the primary member is a retiree, cost-sharing of monthly contributions is based on the retiree contribution rate. If you and your Sandia spouse elect to be covered separately, you may each choose different medical plans, and any eligible dependents may be covered under either spouse; that is, some dependents may be enrolled under one spouse while other dependents are enrolled under the other spouse (dependents may not be covered under both spouses). No employee or retiree may be covered as both a primary member and a dependent under two Sandia medical plans.

Eligible Dependents

If you are the primary covered member under the Kaiser Plan, your Class I dependents who are eligible for participation include your

Tip

You must furnish Kaiser with proof of a dependent's incapacity and dependency within 31 days after Kaiser requests it.

- spouse, not legally separated or divorced from you;
- unmarried child of any age, who, because of a physical handicap or mental impairment, including mental illness
  - is incapable of self-sustaining employment,
  - lives with you (the covered participant) or in an institution or in a home you provide, **and**
  - is financially dependent on you, the covered participant.
- domestic partner who meets all of the following criteria:
  - must be a domestic partner of a nonrepresented, employee (retirees and other employees are not eligible to enroll domestic partners and/or domestic partner dependents),
  - is the same gender as the employee,
  - shares significant financial resources and dependencies,

- has resided with the employee continuously for at least six months in a sole-partner relationship that is intended to be permanent,
- is unmarried,
- is not related to employee by blood (e.g., brothers, sisters, parents, children, cousins, nieces, uncles),
- is at least 18 years of age, and
- has complied with all Sandia requirements for verification of domestic partner eligibility.

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

- unmarried child of your domestic partner under age 19 (see Appendix B for definition of "child");

- unmarried child of your domestic partner age 19 and over, but under age 24, who is financially dependent on you; and

- unmarried child of your domestic partner of any age, who, because of a physical handicap or mental impairment, including mental illness
  - is incapable of self-sustaining employment,
  - lives with you (the covered participant) or in an institution or in a home you provide, **and**
  - is financially dependent on you, the covered participant.

- Other unmarried dependent persons who meet all of the following criteria:
  - is under age 24,
  - is entirely supported by you or your spouse,
  - permanently resides in your household and for whom you or your spouse is the court-appointed guardian (or was before the person's 18th birthday), or whose parent is an enrolled dependent under your family coverage.

See Appendix A, Acronyms and Definitions, for definitions of "child(ren)," "financially dependent persons," and "qualified medical child support order."

Class II dependents are not eligible to enroll in the Kaiser Plan.

Other Eligible Persons

You are also eligible if you reside in the service area, and you are

- An employee who is not Medicare primary (see Continuation and Conversions, page 11-1) on certain leaves of absence;

  NOTE: An employee on inactive status because he/she is on such 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. See Active Employees, page 3-2.

- A non-Medicare-primary surviving spouse of a regular employee or retiree (see Coverage for the Surviving Spouse and Dependents on page 11-4);

- A non-Medicare-primary, long-term disability terminee (see Continuation and Conversions, page 11-1);

- A non-Medicare-primary member who elects and pays for temporary coverage and pays the appropriate premium when required (for COBRA information, see Continuation and Conversions, page 11-5).

Qualified Medical Child Support Order

Generally, your Plan benefits may not be assigned or alienated. However, an exception applies in the case of any child of a participant (as defined by ERISA) who is recognized as an alternate recipient in a Qualified Medical Child Support Order (QMCSO). This Plan will comply with the terms of a QMCSO. A QMCSO is an order or judgment from a court or administrative body directing the plan to cover a child of an insured under a group health plan (see the definition in Appendix A). Federal law provides that a medical child support order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected eligible employee or retiree and each child (or the child's representative) covered by the order will be given notice of the receipt of the order. The Sandia Legal Division will review the order and notify you within 40 business days of the date of notice to Sandia of its review. Coverage under the Plan pursuant to a QMCSO will not become effective until the Plan Administrator determines that the order is a QMCSO. If you have any questions, please contact the Sandia BCSC at 845-BENE (2363).

Eligibility Appeals Procedure

If Kaiser denies your claim or network access or that of a dependent because of eligibility, you may contact the Sandia BCSC at 505-845-BENE (2363) to request a review of eligibility status. Written notification will be sent to you informing you of the decision within three business days of your request. If you are not satisfied with the decision, you may request that your eligibility status or that of your dependent 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 the eligibility provisions of this Plan, to construe its terms, and to determine member eligibility thereunder; however, the determination status of a dependent (due to a physical or mental impairment) for the purpose of determining eligibility under the Plan is the responsibility of Kaiser. 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 pursue any legal recourse.

NOTE: If Kaiser denies your claim or network access due to termination by Kaiser for cause as described under Section 10-2, the eligibility appeals must be processed through Kaiser as described under Section 8, Member Complaint, Grievance, and Appeal Procedures.

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Section 4

Enrollment and Disenrollment

This section outlines the enrollment and disenrollment procedures for new hires, active employees, retirees, and dependents; it also discusses the options to waive/drop coverage altogether.

New Hires/Reclassified Employees

As a new hire or reclassified employee newly eligible for medical care coverage, you can elect to enroll yourself and your dependents in Kaiser **within 31 calendar days of your date of hire or reclassification.** You will be given an enrollment form and a payroll deduction form to complete.

To enroll:

- Complete the KHP Enrollment Application/Change Form. Make a copy of the form as proof of coverage until you receive your ID card(s).
- Complete the payroll deduction authorization, making sure you indicate whether you want your premium to be deducted on a pre-tax or after-tax basis. Refer to the Pre-Tax Premium Plan booklet.

  NOTE: If you do not indicate pre-tax or after-tax on the payroll deduction form, your premium will automatically be taken pre-tax.

- Mail the enrollment form and payroll deduction form to California Benefits and Health Services, MS 9112.

If you enroll in the Kaiser Plan within 31 calendar days, coverage will be retroactive to your date of hire or reclassification. If you do not enroll yourself and your eligible dependents within 31 calendar days of becoming a new hire or a reclassified employee newly eligible for medical coverage, you will be able to

enroll yourself and your eligible dependents in the Basic Preferred Provider Organization (PPO) Plan (so long as you enroll within six months of your hire or reclassification date). If you miss the 31-calendar-day enrollment requirement, you will not be allowed to enroll yourself or your eligible dependents in any Sandia medical plan if there has been an intervening Open Enrollment period when you could have enrolled. You must wait for the next open enrollment period or a mid-year election change event to enroll in a medical plan.

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

NOTE: If your effective coverage date is before the 16th of the month, you will be required to pay the applicable cost-share amount for the month in which you were hired or reclassified. If your effective coverage date is after the 15th of the month, you will not be required to pay the cost-share amount for the month in which you were hired or reclassified.

Notice to New Enrollees About the Continuity of Care Provision

Under state law, you may be eligible to enroll in Kaiser but still receive treatment for an acute condition from your current non-Kaiser provider. If it is determined by Kaiser that you are eligible, Kaiser will give you a written referral to obtain care for your current acute condition.

To qualify for this temporary out-of-network coverage, the continuing services must be medically appropriate, you must meet certain criteria, and you must submit your request no later than 30 days from the start of your health plan coverage. Also, all of the following conditions must be true:

- Your health plan coverage is in effect;
- You are receiving services during a current episode of care for an acute condition from a non-Plan provider on the effective date of your health plan coverage;
- When you chose this health plan, you were not offered other coverage that included an out-of-network option that would have covered the services of your current non-Plan provider;
- You did not have the option to continue with your previous health plan or to choose a plan that covers the services of your current non-Plan provider;

- The non-Plan provider agrees in writing to Kaiser's standard contractual terms and conditions, including conditions pertaining to providing credentials, payment, and providing services within Kaiser's service area; and
- The services to be provided to you by the non-Plan provider are medically necessary and would be covered services under the terms of your health plan coverage if provided by a Plan provider.

Kaiser will deny your request if Plan providers determine that continuity of care can be maintained without temporary coverage of non-Plan providers. To request a copy of the coverage policy, please call the Kaiser Member Services Call Center at 800-464-4000.

Active Employees and Retirees

Eligible persons may elect to enroll in the Kaiser Plan once a year during the Open Enrollment period held each fall. If you enroll in Kaiser during Open Enrollment, Kaiser coverage will be effective January 1 of the following calendar year. Refer to Service Area, page 3-1, for information on enrolling in or disenrolling from Kaiser if you change your residence or have a change in work site to within or outside of the service area.

NOTE: If you are already enrolled in Kaiser and you wish to remain enrolled in Kaiser for the subsequent calendar year, you do NOT need to enroll again through the Open Enrollment Phone System.

Employees and retirees may also enroll if they experience a loss of coverage during the year due to

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

NOTE: The Kaiser Plan is available only in certain ZIP codes in California. If you live in a ZIP code area that is not covered under the Kaiser Plan, you and your covered dependents will have to disenroll from the Kaiser Plan and enroll in another Sandia medical plan, to continue coverage through Sandia.

Enrolling Dependents

Notify the California Benefits and Health Services, 925-294-2254, or Sandia Benefits and Customer Service Center (BCSC), 505-845-BENE (2363), as soon as you gain an eligible dependent. All Class I dependents must be enrolled **within 31 calendar days** of the dependent's eligibility or an election change event, whether or not your premium is taken pre-tax or after-tax (refer to the Pre-Tax Premium Plan Booklet for election change events). You can also enroll eligible dependents during the Open Enrollment period held each fall.

The following information must be provided upon enrollment:

- dependent's name and relationship to you,
- dependent's date of birth, and
- dependent's Social Security number (not applicable to newborns).

If the eligible Class I dependent has other health insurance coverage upon becoming eligible for the Kaiser Plan and declines enrollment, and if in the future, he or she involuntarily loses that coverage, you may be able to enroll the Class I dependent if you request enrollment within 31 calendar days of the loss of coverage.

Coverage for eligible dependents becomes effective on the latter of

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

Newborn dependent children are automatically covered for the first 31 calendar days but must be enrolled with the Sandia BCSC within 31 calendar days of their birth to continue coverage. Call the BCSC at 505-845-BENE (2363) for enrollment instructions. Coverage for a newborn whom you enrolled with Sandia BCSC becomes effective on the date of the birth.

Coverage for an adopted child whom you enroll with the Sandia BCSC begins when the child is placed with you for adoption so long as written notification and the placement agreement and/or final adoption papers are received by the BCSC

within 31 calendar days of the placement for adoption. Medical expenses of the child before adoption, including the birth mother's prenatal, postnatal, and delivery charges, are not covered.

Upon timely application, coverage for dependents gained as a result of marriage or legal guardianship will be effective on the date of enrollment, and you will pay premiums from that day forward. Coverage for births, adoptions, or placements for adoption will be retroactive to the event, and premiums will be charged retroactively.

NOTE: You will not be eligible to enroll your dependents if there has been an intervening open enrollment period when the dependent(s) could have been enrolled.

NOTE: If you enroll a new dependent and your cost-share amount changes, the following will apply:

- If the effective coverage date for your new dependent is before the 16th of the month, you will be required to pay the new applicable cost-share amount for that entire month.
- If the effective coverage date for your new dependent is after the 15th of the month, you will NOT be required to pay the new applicable cost-share amount for that month.

If you do not enroll your eligible dependent within 31 calendar days of a marriage, birth, adoption, placement for adoption, or obtaining legal guardianship, you will be able to enroll your eligible dependent in the Kaiser Plan within six months of the marriage, birth, adoption, placement for adoption, or obtaining legal guardianship, but you will have to pay the applicable premium-share on an after-tax basis. If the enrollment does not cause any change to your premium-share amount, for example, you are already paying for a family of three or more, you will be able to enroll the dependent at no additional cost to you. If you elect coverage under this option, you must remember to enroll your eligible dependent under the next Open Enrollment period in order to have coverage in the subsequent calendar year.

NOTE: You will not be eligible to enroll your dependents if there has been an intervening open enrollment period when the dependent(s) could have been enrolled.

To Enroll an Eligible Dependent

1. Complete a Kaiser Enrollment Application/Change Form (newborns do not need to have a Social Security number to be enrolled);

2. Complete the Medical Insurance Premium Form, if applicable (second and third dependents only);

3. Retain a copy for your files; and

4. Mail the original forms to the Sandia California Benefits and Health Services at MS9112 within 31 calendar days of the dependent's eligibility or mid-year election change event.

Forms are available from Sandia California Benefits and Health Services at 925-294-2254, the Sandia BCSC at 505-845-BENE (2363), or the web. To access the forms on the web, go to the Corporate Forms web page, select Benefits from the left column, then select SF4400-KAI and SF4811-HCC.

You must enroll your eligible dependent in the dental and vision plans separately by using a separate form, which is available from the Sandia BCSC or the Corporate Forms web page under Benefits, SF4400-ADV.

Disenrolling Dependents

If you are a retiree or an employee who is having the medical premium deducted from your paycheck on an after-tax basis, you can disenroll your covered dependents at any time during the year; however, if a covered dependent loses eligibility, you must notify the Sandia California Benefits and Health Services or the Sandia BCSC immediately. The effective date of disenrollment will be the last day of the month in which the covered dependent became ineligible.

If you are an employee who is having the medical premium deducted from your paycheck on a pretax basis, you can disenroll a covered dependent only if the covered dependent loses eligibility or upon an election change event (and you disenroll the covered dependent within 31 calendar days of the mid-year election change event). (Refer to the Pre-Tax Premium Plan booklet.)

If you fail to disenroll your covered dependent by the end of the month in which the covered dependent became ineligible, upon learning of this failure, Sandia California Benefits and Health Services or the Sandia BCSC (505-845-BENE [2363]), will retroactively terminate coverage for your covered dependent to the last day of the month in which the covered dependent became ineligible, and you will be responsible for reimbursing Sandia for all monthly premium costs paid on behalf of your dependents. You will also be responsible for reimbursing any services or supplies incurred after your dependent lost eligibility. You may also be considered for disciplinary action for fraudulent use of the Kaiser Plan.

IMPORTANT **If you or your ex-dependent notify Sandia of the loss of eligibility of the dependent after the 60-day notification period for COBRA has expired, the ex-dependent is not entitled to continue coverage through Sandia under COBRA.**

To disenroll a dependent,

- complete the Kaiser Enrollment Application/Change Form,
- retain a copy for your files, and
- mail the original to the Sandia California Benefits and Health Services at MS9112 within 31 calendar days of the loss of dependent eligibility.

Forms are available from Sandia California Benefits and Health Services at 925-294-2254, the Sandia BCSC at 505-845-BENE (2363), or the web. To access the forms on the Corporate Forms web page, select Benefits from the left column, then select SF4400-KAI.

IMPORTANT **If your dependent also became ineligible for dental and vision coverage, you need to complete a separate form, SF4400-DVD, which is available from the Sandia BCSC or the Sandia web within 31 calendar days.**

Sandia abides by a federal law referred to as the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1987, in which temporary continued coverage is provided to dependents who would otherwise lose group coverage because of specified events. (Refer to Continuation and Conversions, page 11-1, for more information.) However, failure to disenroll your dependent in a timely manner as described above will result in loss of COBRA rights.

Election Change Events Allowing Mid-Year Election Changes

Mid-year election change events may permit changes to your health care coverage election at times other than during Open Enrollment so long as written notification is provided to the Benefits Department within 31 calendar days of the election change event, and the mid-year election change is consistent with and on account of the event. Generally, the new election is effective on the **later** of the status change date or the date of written notification to the Benefits Department. In the case of a birth, adoption, or placement for adoption, the coverage will be retroactive to the event, subject to enrollment rules. In the case of disenrollment because of ineligibility, the effective date will be the last day of the month in which the covered dependent became ineligible. In the case of disenrollment for

any other reason, the effective date will be the last day of the month in which written notification was received by the Benefits Department or the status change date, whichever is later. Refer to the Pre-Tax Premium Plan booklet for more comprehensive information on mid-year election change events.

NOTE: These mid-year election changes allowing enrollment apply whether your medical premium is deducted pre- or after-tax.

Waiving/Dropping Coverage in Sandia-Sponsored Medical Plans

You have the option to waive coverage for yourself and your eligible dependents during the annual Open Enrollment period held each fall. If your premiums are deducted on an **after-tax basis**, you may also drop coverage for yourself and your covered dependents at any time during the year. If your premium is deducted on a **pre-tax basis**, you can drop coverage for yourself and your covered dependents outside of the Open Enrollment period held each fall only if you experience a mid-year election change event. (See Election Change Events Allowing Mid-Year Election Changes, page 4-7 and the Pre-Tax Premium Plan booklet.)

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

Coverage for any eligible dependent is based on your coverage as an employee; therefore, if you waive/drop coverage for yourself, you are also waiving/dropping coverage for all of your covered and/or eligible dependents. Coverage will end on the last day of the month in which you waive/drop coverage. If you waive/drop coverage, you will have the option to reinstate the coverage during the Open Enrollment period held each fall with coverage becoming effective January 1 of the following calendar year.

Under the Health Insurance Portability and Accountability Act (HIPAA), if you waive/drop coverage for yourself and your covered dependents because of other health insurance coverage, and you and 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 within 31 calendar days after the other coverage ends. In addition, if you acquire a new eligible dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 31 calendar days after the marriage, birth, adoption, or placement for adoption.

Employees enrolled in the Kaiser Plan have the **option** to cancel their coverage upon meeting the requirements of the Family and Medical Leave Act (FMLA). Written notification to cancel coverage must be received by Sandia California Benefits and Health Services 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 California Benefits and Health Services receives written notification. If you do not cancel the coverage, it will be continued, and premiums will be deducted (on a pre-tax or after-tax basis) during sickness absence, or made up when you return from an unpaid absence. If your absence is classified as a Leave of Absence, you will receive paperwork from the Sandia BCSC to continue paying your premiums monthly, on an after-tax basis. If you do not continue to pay premiums during a leave of absence, your coverage will be canceled.

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

An employee can reenroll by notifying the Sandia BCSC or California Benefits and Health Services in writing within 31 calendar days of returning to work. If notification to the Sandia BCSC to reinstate medical coverage for you and your eligible dependents is not received in writing within 31 calendar days of the date you return from the absence, you cannot reinstate medical coverage until the following calendar year, provided that the election is made during the next applicable Open Enrollment period.

If you are planning to take paid or unpaid time off, contact the Sandia BCSC at 505-845-BENE (2363).

NOTE: Members who voluntarily terminate Plan coverage for themselves and their covered and/or eligible dependents while still employed with Sandia are not eligible for any COBRA continuation or individual conversion.

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Section 5

Accessing Care

When you enroll in the Kaiser Plan, you are selecting Kaiser physicians and facilities to provide your medical care. All of your health care is provided by Kaiser medical facilities unless otherwise arranged by a Kaiser Medical Group physician or unless it meets the criteria described under the sections Services and Benefits, page 6-1, and Out-of-Plan Emergency Care, page 7-1.

Using Your Identification Card

After enrolling in Kaiser, each member will be issued a health plan ID card with a medical record number on it, which is important when you call for advice, make an appointment, or go to a Plan provider for care. The medical record number is used to identify your medical records and membership information.

IMPORTANT **Your ID card is for identification only. To receive covered services, you must be a member. Anyone who is not a Kaiser member will be charged nonmember rates for any services. If you let someone else use your card, Kaiser can keep your card and may terminate your membership.**

Choosing Your Personal Physician

You and your dependents are encouraged to choose a personal Plan physician who will coordinate all your health care needs, including hospital stays and referrals to specialists. You may select a personal Plan physician from the following specialties as appropriate for you: internal medicine, obstetrics/gynecology, family practice, and pediatrics. You can receive care from these and certain other specialties without a referral from a Plan physician. Please refer to your facility's listing in *The Guidebook to Kaiser Permanente Services* for the specialty departments that require a referral. To learn how to choose or change a Plan physician, call the Kaiser Member Services Call Center at 800-464-4000.

Also, you may receive a second medical opinion from a Plan physician upon request.

Getting a Referral

Plan physicians offer primary medical, pediatric, and ob/gyn care as well as specialty care in areas such as general surgery, orthopedic surgery, and dermatology. If your Plan physician decides that you require covered services and supplies not available from Kaiser, he or she will refer you to a non-Plan provider inside or outside Kaiser's service area. You must have a written referral to the non-Plan provider in order for Kaiser to cover the service and supplies. Copayments for referral services and supplies are the same as those required for services and supplies provided by a Plan provider.

Making an Appointment

Unless you have a medical emergency, you should make an appointment before visiting Kaiser medical offices. You will find addresses and telephone numbers for medical facilities in the Kaiser pamphlet, *Our Locations*, available from the Sandia California Benefits and Health Services office or through the KHP website: http://www.KaiserPermanente.org.

When you call to discuss a medical problem, Kaiser can help you determine whether you need a routine appointment or an urgent, same-day appointment.

Specialists and Other Services

You have access to Kaiser Medical Group physicians who provide specialty services such as general surgery, orthopedic surgery, and dermatology. Your Medical Group physician will refer to you to a specialist when necessary. Other covered medical services such as physical therapy, laboratory, and x-ray services are available at the medical offices.

Call 800-464-4000 to obtain a copy of the *Member's Rights and Responsibilities Handbook*.

Your Rights and Responsibilities

As a Kaiser member, it is important for you to know your rights and responsibilities. Below are lists of your rights and responsibilities as a Kaiser member.

Your Rights

You have the right to

- receive information about your health Plan;
- participate in a candid discussion of all available treatment options;
- express your wishes about future care;
- receive information about the people who provide your health care;
- expect your doctor and his/her staff to demonstrate respect and common courtesy when you are treated;
- have impartial access to treatment;
- have interpreter services in your primary language;
- privacy and confidentiality;
- have a safe, secure, clean, and accessible health care environment;
- participate in physician selection; and
- know and use member satisfaction resources.

Your Responsibilities

You have the responsibility to

- know the extent and limitations of your health care benefits;
- identify yourself;
- keep appointments;
- provide accurate and complete information;
- follow the treatment plan you and your health care practitioner agree on;
- recognize the effect of your lifestyle on your health;
- be considerate of others;
- fulfill financial obligations;
- know and use member satisfaction resources, including the complaint, grievance, and appeals processes; and
- notify Kaiser if you are hospitalized in a non-KHP hospital.

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Section 6

Services and Benefits

Benefits are provided only for medically necessary covered services that are prescribed, provided, authorized, or directed by a Medical Group physician to prevent, diagnose, or treat a medical condition. The services and supplies described in this section are covered only if all of the following conditions are satisfied:

- A Plan physician determines that the services and supplies are medically necessary to prevent, diagnose, or treat your medical condition. A service or supply is medically necessary only if a Plan physician determines that it is medically appropriate for you and its omission would adversely affect your health.
- The services and supplies are provided, prescribed, authorized, or directed by a Plan physician.
- You receive the services and supplies at a Plan facility or skilled nursing facility inside Kaiser's service area.

Kaiser will not pay for other services except for Out-of-Plan emergency-care services and authorized referrals by a Medical Group physician.

Exclusions and limitations that generally affect benefits and services are described under General Exclusions and Limitations, page 6-8.

Employees and Retirees (Non-Medicare)

Benefit	Copays	Comments
Annual Deductible	N/A	No deductibles apply.
Out-of-Pocket Maximum (annual)	$1,500/one person $3,000/two or more persons **NOTE:** Does not apply to coinsurance expenses.	Applies only to the following service types: ■ Professional services ■ Hospital care ■ Physical and occupational therapies and multidisciplinary rehabilitation ■ Imaging, lab tests, and special procedures. **NOTE:** The member is responsible for tracking annual copay costs.
Acupuncture	$10 per visit	When prescribed by a Plan physician. Maximum of 60 consecutive days per condition per lifetime.
Behavioral Health Alcohol and drug dependency treatment		Outpatient coverage includes ■ Day treatment programs ■ Intensive outpatient programs
■ Outpatient individual therapy visits	$10 per visit	■ Medical treatment for withdrawal symptoms ■ Methadone
■ Outpatient group therapy visits	$5 per visit	■ Maintenance treatment for pregnant members during pregnancy and for two months after delivery at a licensed treatment center approved by the Medical Group.
■ Inpatient detoxification	$250 per admission	Inpatient hospitalization is covered in a Plan hospital only for medical management of withdrawal symptoms, including dependency recovery services, supplies, education, and counseling.
■ Transitional residential recovery services	$250 per admission	Transitional residential recovery services are covered up to 60 days per calendar year in a nonmedical transitional residential recovery setting if approved in writing by Kaiser. No more than 120 days of covered care are provided in any consecutive calendar-year period.
Ambulance Service	$75 per trip	The ambulance service is covered if authorized by a Kaiser Medical Group physician or if the medical condition causes sudden symptoms of such severity (including severe pain) that, in using the reasonable judgment of a prudent layperson with an average knowledge of health and medicine, you believe that (1) the damage to your body or bodily functions and (2) your condition require the use of medical services and supplies that only a licensed ambulance can provide. See Emergency Care, page 7-1, for a description of emergency service.

Benefit	Copays	Comments
Chiropractic	$10 per visit	Plan covers up to 20 visits per calendar year. Chiropractic services are provided by American Specialty Health Plan in-network physicians only. Contact Benefits at (925-294-2254) for additional access information.
Dental (Accidental Injury only)	No charge	Dental services to restore or repair a sound natural tooth that was damaged in an accidental injury. Dental reimbursement for service and supplies provided through Delta Dental. Contact Benefits (925-294-2254) for claim processing information.
Dialysis Care ■ Physician office visits ■ Dialysis treatment visits	 $10 per visit $10 per visit	Dialysis services and supplies related to acute renal failure and end-stage renal disease are covered if the following criteria are met: ■ The services and supplies are provided within the service area. ■ You satisfy all medical criteria developed by the Medical Group and by the facility providing the dialysis. ■ A Plan physician provides a written referral for care at the facility. After referral to a dialysis facility, Kaiser covers equipment, training, and medical supplies required for home dialysis.
Durable Medical Equipment Equipment in accordance with Kaiser durable medical equipment (DME) guidelines	100% benefit coverage	Durable medical equipment is covered only within the service area. Coverage is limited to the standard item of equipment that adequately meets your medical needs. Durable medical equipment is an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use in the home. Coverage is based on Plan physician prescription for use in your home.
Emergency Care ■ In area ■ Out of area	 $75 per visit $75 per visit	 Copay waived if patient is admitted to the hospital. Worldwide coverage for emergency services due to unforeseen illness or injury; this is limited to emergency services required before the member's condition permits transfer or travel to the nearest Kaiser facility. Follow-up care is not covered.
Family Planning	$10 per visit	Services for family planning related to the following: ■ Family planning counseling, including preabortion and postabortion counseling and information on birth control; ■ Tubal ligations; ■ Vasectomies; ■ Voluntary termination of pregnancy.
Health Education ■ Education services for specific conditions, such as diabetes counseling ■ General health education such as Lamaze classes ■ Health education publications	 $10 per visit Charges vary	 Each medical facility has its own classes, seminars, and resources.
Home Health Services	No charge when authorized by Plan physician (Up to 100 two-hour visits per calendar year)	■ Must be directed by Home Health Committee. ■ Not covered outside of service area. ■ Custodial and homemaker care not included.

Benefit	Copays	Comments
Hospice Care ■ Provided for terminally ill patients ■ Provided by licensed hospices ■ Physician services ■ Nursing care ■ Therapies ■ Medical social service ■ Services of home health aides and homemakers ■ Prescribed drugs ■ Short-term inpatient care ■ Counseling and bereavement services ■ Services of volunteers	No charge when authorized by Plan physician	■ Not provided outside service area. ■ Not entitled to any other benefits for the terminal illness. ■ Kaiser does not cover hospice care for members with Medicare Parts A and B. For those members, if your Kaiser Plan physician determines you are eligible for and you wish to elect hospice care, Kaiser will assist you in identifying Medicare-certified hospices, including any Kaiser Permanente hospice, in your area. The hospice will bill Medicare directly for care ordered by the hospice team.
Hospital Care ■ Physician and surgical services ■ Room and board ■ Special diets ■ General nursing care ■ Private room when medically needed ■ Operating and recovery room ■ Anesthesia ■ Intensive care ■ Hospital and physician services for mother and child during mother's hospitalization ■ Prescribed drugs and medical supplies ■ Respiratory therapy ■ Visits for x-rays, laboratory tests, and other diagnostic tests ■ Dressings, casts, and durable medical equipment ■ Medical social services and discharge planning ■ Blood, blood products, blood transfusions	$250 per admission	No limit to number of covered hospital days, except for mental health hospitalization.

Benefit	Copays	Comments
Infertility	$10 per visit	Infertility services are covered as follows: ■ Services and supplies for diagnosis and treatment of involuntary infertility ■ Artificial insemination (except for donor semen or eggs and services and supplies related to their procurement and storage) ■ Exclusions include all services and supplies (other than artificial insemination) related to conception by artificial means, such as but not limited to – Ovum transplants – Gamete intrafallopian transfer (GIFT) – Donor semen or eggs and services and supplies related to their procurement and storage – In vitro fertilization (IVF) – Zygote intrafallopian transfer (ZIFT) – Services and supplies to reverse voluntary, surgically induced infertility.
Maternity ■ Prenatal ■ Postnatal	 No charge No charge first visit $10 thereafter	
Mental Health ■ Short-term psychiatric inpatient care and hospital alternative care ■ Outpatient short-term therapy	 No charge for inpatient $10 per individual visit; $2.50 per group visit	 Maximum of 45 days per calendar year and no more than 60 days per any consecutive five-year period. Up to 20 visits per calendar year.
Outpatient Care ■ Routine office visits – Diagnosis and treatment of illness or injury – Preventive care – Immunizations – X-rays, laboratory, and other diagnostic tests – Eye exams for eyeglasses – Hearing tests – Respiratory therapy – Prescribed drugs, injectables – Same-day surgery – Ultraviolet light treatment – Allergy testing and treatment – Blood, blood products, and blood transfusions – Post-transplant care – Emergency room unless admitted – Consultation and care by specialists, including second opinions – Radioactive materials used for therapeutic purposes	 $10 per visit $10 per visit $10 per visit No charge No charge $10 per visit $10 per visit $10 per visit No charge $50 per visit No charge $10 per visit No charge $10 per visit $75 per visit $10 per visit No charge	No limit to the number of covered visits (except for mental health) as long as medically necessary.

Benefit	Copays	Comments
Prescribed Drugs, Supplies, and Supplements ■ Cancer chemotherapy drugs and critical adjuncts ■ Amino-acid-modified products to treat congenital errors of amino-acid metabolism ■ Intravenous (IV) fluids, drugs, additives and nutrients, including IV equipment and infusion pumps ■ Prescribed dressings and casts ■ Ostomy and urological supplies	No charge	Provided in accordance with the Health Plan's prescription drug formulary.
Prescription Drugs ■ Generic	$10 for up to a 30-day supply maximum at a Plan Pharmacy or Mail Order Program $20 for up to a 100-day supply maximum for refills obtained through Mail Order Program	Covered drugs and accessories must be prescribed by a physician or dentist in accordance with Health Plan formulary guidelines and must be purchased from a Kaiser pharmacy.
■ Brand name and compounded drugs	$20 for up to a 30-day supply maximum at a Plan Pharmacy or Mail Order Program $40 for up to a 100-day supply maximum for refills obtained through Mail Order Program	Mail Order Program (MOP): Many refills are available through Kaiser MOP. Kaiser Plan Pharmacies can give you details, including whether you can use the MOP to refill your prescription.
Prosthetic and Orthotic Devices and Braces	No charge	■ Prostheses needed after a medically necessary mastectomy, including custom-made prostheses. ■ Provided only in the service area. ■ Limited to the standard item of the device or brace. Exclusions: Electronic voice-producing machines and hearing aids; convenience and luxury items.
Reconstructive Surgery		
■ Inpatient care	$250 per admission	■ Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if a Plan physician determines that it is necessary to improve function or create a normal appearance, to the extent possible. ■ Reconstructive surgery following medically necessary removal of all or part of a breast. ■ Reconstructive surgery of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedema.
■ Office visits	$10 per visit	
■ Same-day outpatient surgery	$50 per procedure	

Benefit	Copays	Comments
Skilled Nursing Facility Care ■ Physician and nursing services ■ Room and board ■ Medical social services ■ Prescribed drugs and medical supplies ■ Blood, blood products, and their administration ■ Durable medical equipment ordinarily furnished by the skilled nursing facility ■ Laboratory and x-ray services ■ Services and supplies covered under therapies	No charge	Up to 100 days of prescribed extended care services per benefit period at approved facilities. Limitations: Rehabilitation services are limited to a single course of treatment per condition, up to two months.
Therapies – Physical, Speech, Occupational, and Rehabilitation ■ Provided in increments of two-month periods ■ Single course of treatment per condition	$10 per visit	Exclusions and limitations: ■ Speech therapy for problems with a specific organic origin ■ Occupational therapy only for services that will improve self-care and other customary activities of daily living
Transplants ■ Inpatient care ■ Physician office visits	$250 per admission No charge $10 per visit	■ Satisfaction of all Kaiser-developed medical criteria ■ A Plan physician provides a written referral for care at the facility ■ The facility is certified by Medicare to perform transplants Exclusion: Nonhuman or artificial organs and implantation.
Vision Coverage Exam/glaucoma screening Contact lens exam Eyeglass lens Eyeglass frames	 $10 per visit $33 per visit N/A N/A	

General Exclusions and Limitations

The general exclusions listed below apply to all services and benefits that would otherwise be covered. They are in addition to the exclusions that apply to particular benefits. These are listed in the comments column of that benefit in Services and Benefits starting on page 6-1. Whenever the word "service" is used, it refers to any drug, equipment, device, treatment, or therapeutic or diagnostic procedure. When a particular service is excluded, all services that are necessary for that excluded service are also excluded, even if they would otherwise be covered.

Exclusions	Examples
Certain exams, services and supplies	■ Physical examinations and other services and supplies (a) required for obtaining or maintaining employment or participation in employee programs, or (b) required for insurance or licensing, or (c) on court order or required for parole or probation. This exclusion does not apply if a Plan physician determines that the services and supplies are medically necessary.
Cosmetic Services	■ Plastic surgery or other cosmetic services that are indicated primarily to improve the member's appearance, except for services and supplies covered under "Reconstructive Surgery" on page 6-6.
Custodial Care	■ Assistance with activities of daily living. ■ Care that can be performed safely and effectively by persons who, in order to provide the care, do not require medical licenses or certificates, who are not required to be in the presence of a supervising licensed nurse.
Dental care and x-rays	■ Dental care and dental x-rays, dental appliances, dental implants, orthodontia, and dental services and supplies resulting from medical treatment such as surgery on the jawbone and radiation treatment. (See Services and Benefits for Dental [accidental injury only] benefit coverage (on page 6-3).
Experimental or investigational services and supplies	■ Not recognized in accordance with generally accepted medical standards as safe and effective for treating the condition. ■ Requires approval by any governmental authority before use.
Government agency	■ Financial responsibility for services and supplies that a government agency is required by law to provide.
Intermediate care facility	■ Care in an intermediate care facility.
Military service	■ Services and supplies for conditions arising from military service that are reasonably available from the Veterans Administration.
Miscellaneous	■ Service not generally or customarily available in the Kaiser service area, except when it is a generally accepted medical practice in Kaiser's service area to refer patients outside our service area for the service or supply. ■ All services related to sex change. ■ Routine foot care not medically necessary. ■ Work-related injury or illness.

Section 7

Emergency Care

You are covered for medical emergencies anywhere in the world. For information about emergency benefits away from home, call California Benefits and Health Services (925-294-2254) or a Kaiser member service representative at 800-464-4000 to request a travel packet.

Emergency care means medically necessary health services immediately required for unforeseen illness or injury as determined by Kaiser, but only if the services would have been covered had a Plan physician prescribed, provided, or directed them.

Emergency Care Received from Kaiser Facilities

Emergency care is available from Kaiser Hospital medical centers or Kaiser contracted hospitals 24 hours a day, 7 days a week.

If you are not sure whether your situation is an emergency, call the emergency telephone number of the nearest Kaiser Hospital medical center or Kaiser contracted hospital. Kaiser will authorize an ambulance if it is medically necessary, or if the situation is a life-threatening emergency, call 911 immediately.

Out-of-Plan Emergency Care

Out-of-Plan emergency care is emergency care that is provided by non-Plan providers and is not authorized in advance by a Medical Group physician.

If you receive out-of-Plan emergency care in a hospital, you or a member of your family must notify Kaiser within 24 hours or as soon as reasonably possible. Call the number on the front of your ID card. Kaiser will then make arrangements for any necessary continued hospitalization or for transferring you to a hospital approved by Kaiser. By notifying Kaiser of your hospitalization, you will protect

yourself from potential liability for payment for services you received, after transfer to a Kaiser facility would have been possible.

Your eligibility for reimbursement depends on an objective determination of the situation by Kaiser and not solely on the advice of the non-Plan provider that an emergency existed.

Inside the service area: Kaiser will cover out-of-Plan emergency care if going to a Kaiser medical facility would have caused a delay resulting in death, serious disability, or significant jeopardy to your condition.

Outside the service area: If you become ill or injured while outside the service area, Kaiser will cover the out-of-Plan emergency services you receive if the services could not be delayed until you could get to one of the Kaiser medical facilities in the service area.

Limitation and Reductions: Coverage of out-of Plan emergency care is limited to emergency care that is required before your medical condition would permit your transfer or travel to a Kaiser medical facility or other facility approved by Kaiser. Special transportation will be covered if it is medically necessary to transport you to such a facility and if approval was received in advance. Unauthorized continuing or follow-up care outside of Kaiser will not be covered.

Receiving Reimbursement for Out-of-Plan Emergency Care

Payments are reduced by any copayments you would have had to pay if you had received the services from Plan providers.

Obtain emergency care claim forms by calling 510-987-1400 or writing the nearest Kaiser member service office. You must submit a completed claim form within 90 days or as soon as reasonably possible after you receive the services, but in no event will payment be made unless you submit a complete claim within 12 months.

Send the completed and signed form to the following address:

Kaiser Foundation Health Plan, Inc.
Claims Department
P. O. Box 12923
Oakland, CA 94604

Your claim will be acted upon within 30 days after receipt by Kaiser. If your claim is denied in whole or in part, you will receive a written decision including

the reasons for denial, the pertinent Plan provision(s) on which the denial was based, and an explanation of your right to appeal the decision.

Your claim will be acted upon within 30 days after receipt by Kaiser unless Kaiser notifies you, within that initial 30 days, that additional information is needed from you or the non-Plan providers. Kaiser must receive the additional information within 45 days of the request in order for the information to be considered in the decision. A written decision will be sent within 15 days of receiving the additional information. However, if Kaiser does not receive the additional information within 45 days of the request, Kaiser will send a written decision no later than 90 days from the date of the initial request for payment.

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Section 8

Member Complaint, Grievance, and Appeal Procedures

If you have a question or a complaint about the Health Plan, Plan providers, personnel, facilities, or the care you received, you are encouraged to contact a patient assistance coordinator or a member service representative at your local Kaiser facility or call the Member Service Call Center at 800-464-4000. The representative will try to resolve the problem for you.

Filing a Grievance

If the problem is not resolved to your satisfaction through the patient assistance coordinator, the member service representative, or the Member Service Call Center, you may submit a written grievance to a member service representative at the facility. The representative will also assist you with writing the grievance if needed. Receipt of the grievance will be acknowledged within five business days. The acknowledgment letter will include the name of the member service representative who will respond to you on behalf of the facility's Medical Center Review Committee and offer you the opportunity to appear before the committee to present your case if you wish to do so. The committee's decision will be made within 30 days after the written grievance has been received. Should additional time be needed to gather more information, you will be notified in writing. A grievance will be resolved no later than 60 days from the date Kaiser received it.

Appeals

If you disagree with the decision of the Medical Center Review Committee, you may file a written appeal. A member service representative can assist you with a written appeal. You must send your appeal to the Member Relations Department,

at the address specified in the initial response, within one year after you receive the decision. The appeal must set forth the reasons you believe the decision was in error. Your appeal will be acknowledged within five business days and will include the name of the member relations specialist representative who will respond to you on behalf of the Appeals Committee and offer you the opportunity to appear before the committee to present your case if you wish to do so. You may examine pertinent documents related to your request unless they are subject to legal or other privileges. Also, you can submit additional written material for consideration.

You will receive a written response to your appeal within 30 days from the date Kaiser receives it, unless you are notified that additional time is needed to consider your grievance appeal. An appeal will be resolved no later than 60 days from the date Kaiser received it. When the grievance appeal process is completed, you will receive a written decision. If your grievance or grievance appeal is denied in whole or in part, you will be informed of the reasons and, if you wish to pursue your grievance further, the procedure for submitting the dispute to binding arbitration will be explained to you.

Requesting an Expedited Review

This procedure applies to requests for services and/or supplies that you have not received and that you believe are medically urgent. In addition, the procedure applies if you believe that Kaiser should provide, arrange, or continue the service or supply. You may ask Kaiser to expedite a decision about your request at the initial grievance or appeal level. Kaiser will expedite the review of your request if it finds or if your physician states that your health or ability to function could be seriously harmed by waiting 30 days for a decision about the requested services or supplies under the standard 30-day time period as described above. If your request for an expedited review is denied, you will be notified in writing, and your request will automatically be reviewed under the standard review procedure described above. You do not need to submit a separate request.

A request for an expedited review may be made orally or in writing. You or your physician may request an expedited decision by calling toll-free 888-987-7247 or by sending your written request to:

Kaiser Foundation Health Plan, Inc.
FSCR/Special Services Department
P. O. Box 23280
Oakland, CA 94723
Attn: Expedited Review

You may also fax your request to 888-987-2252, or deliver your request in person to your local member services department. Specifically state that you want an expedited decision.

The following persons may file a request for an expedited review:

- You (for yourself or a dependent child).
- An individual of your choice. If you want someone to file for you, provide:
  - your name,
  - your medical record number, and
  - a statement that appoints an individual as your representative.

  EXAMPLE: An example of a statement is, "I (your name) appoint (name of representative) to act as my representative in requesting an appeal from Kaiser regarding Kaiser's (denial) (discontinuation) of services." You must sign and date the statement. Your representative must also sign and date this statement unless he/she is an attorney. Include the signed statement with your appeal.
- A court-appointed guardian or an agent under a health care proxy, to the extent that state law provides.

If you have a terminal condition that your Plan physician determines has a high probability of causing death within two years, and the Health Plan determines that a proposed treatment is experimental or investigational, you may request, in some cases, an external independent review of the Kaiser Plan's decision.

For information about how to obtain that review, please call a member service representative at 800-644-4000.

Support for Your Request

It would be helpful for you to include any information that clarifies or supports your position. For example, you may want to include with your request information such as medical records or physician opinions that support your appeal. Kaiser will obtain medical records from Plan providers on your behalf. If you have consulted with a non-Plan provider, you will need to contact him/her to obtain your medical records. You may need to mail or fax a written request. Ask your physician to mail or fax the records directly to Kaiser.

A Special Note about DOC Review of Member Complaints

The California Department of Managed Health Care is responsible for regulating health care service plans. The department has a toll-free telephone number, **800-HM02219**, to receive complaints regarding health plans. If you have a grievance, you should contact a Kaiser Plan member service representative and use the Kaiser Plan's grievance process. If you need help with a complaint

involving an emergency grievance or with a grievance that has not been satisfactorily resolved by the Kaiser Plan, you may call the California Department of Managed Health Care's toll-free telephone number listed above.

Required Arbitration Provision

Except for Small Claims Court cases, any claim arising from or relating to a violation of any duty arising from or relating to your agreement with the Kaiser Plan, including any claim for medical or hospital negligence, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this agreement, irrespective of the legal theories upon which the claim is asserted, is subject to binding neutral arbitration. This means that except for Small Claims Court cases, all parties give up their rights to a jury or court trial.

You may initiate arbitration by sending to the regional Kaiser legal department a letter titled "Demand for Arbitration," setting forth the specifics of your claim.

Contact a member service representative at your nearest member service office, by mail or telephone, to obtain a complete copy of the arbitration provision in the Health Plan Service Agreement.

If you have a complaint about the quality of care or service, contact a Member Service representative or a Patient Assistance coordinator at your local Plan facility or call the Member Service Call Center toll free at 800-443-0815 (800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week. A Kaiser representative will advise you about the resolution process and ensure that the appropriate parties review your complaint.

Member Complaint and Grievance Procedures

Kaiser will make every attempt to resolve your issue promptly and will send you its decision within 30 days of receiving a complaint or grievance (unless you are notified that additional time is needed). In the case of a grievance and any subsequent grievance-appeal, Kaiser has 30 days to respond. You will be sent a letter confirming receipt of your complaint, grievance, or grievance-appeal within five days.

How to File a Grievance

For issues other than service, you may submit a grievance to a Member Service representative at any Plan facility. A representative will be happy to help you if you need assistance writing the grievance. Kaiser will notify you about your ability to present your case in person and to have someone represent you if needed.

If your grievance is denied in whole or in part, you will receive a denial letter giving the reasons. You may request an appeal of the denial. Send your grievance-appeal to the Member Relations Department at the address specified in the grievance denial letter within six months. The appeal must set forth the reasons you believe the decision was in error.

You will be informed in writing of Kaiser's decision about your grievance-appeal within 30 days. If Kaiser denies your appeal in whole or in part, the written decision will fully explain the reasons for the denial. You will also be given information about additional dispute resolution options that may apply, such as binding arbitration.

Peer Review Organization Complaint Procedure

If you are concerned about the quality of the care you have received, you may also file a complaint with the local Peer Review Organization, by writing to

California Medical Review, Inc.
1 Sansome Street
Suite 600
San Francisco, CA 94104-4448
Fax number 1-415-677-2185,
or call toll free at 1-800-841-1602

See Appendix A, Definitions, for a definition of Peer Review Organization. The Peer Review Organization review process is designed to help stop any improper practices.

Who May File

The following persons may file a complaint, grievance, appeal, or reconsideration request:

- You (for yourself).
- An individual of your choice. If you want someone to file for you, provide in writing
  - your name,
  - your medical record number, and
  - a statement that appoints an individual as your authorized representative.

EXAMPLE: **"**I [your name] appoint [name of representative] to act as my representative in requesting an appeal or reconsideration request from Kaiser Permanente (or CMS) regarding Kaiser Permanente's [denial] [discontinuation] of services or supplies." You must sign and date the statement.

- Your representative must also sign and date this statement unless he/she is an attorney. Include this signed statement with your appeal or reconsideration request. (Authorization forms are also available from any Member Services Department.)

- You may generally file for a dependent child. In some cases, you may be required to be appointed by your child as his or her authorized representative.
- A non-Plan provider may file a standard reconsideration request of a denied claim if he/she completes a waiver of liability statement that says he/she will not bill you regardless of the outcome of the reconsideration request.
- A court-appointed guardian or an agent under a health care proxy to the extent state law provides.

California Department of Managed Health Care (DMHC) Complaints

The California Department of Managed Health Care (DMHC) requires that Kaiser advise members of the following:

> The California Department of Managed Health Care is responsible for regulating health care service plans. The department has a toll-free telephone number **888-HMO-2219** to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone number **877-688-9891 (TDD)** to contact the department. The department's Internet website **(http://www.hmohelp.ca.gov)** has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan at **800-464-4000** and use the plan's grievance process before contacting the department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your Plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. The Plan's grievance process and the department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

Section 9
Subrogation Rights

Subrogation means Kaiser's right to recover any Plan costs because of an illness or injury to you or your covered dependent when that illness or injury was caused by a third party's wrongful act or negligence and for which you or your covered dependent have a right of action or later recovered payments from the third party.

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

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

Kaiser will be subrogated only to the extent of the Plan benefits paid for that injury.

NOTE: If the injured party is a minor dependent, the primary member must perform the above agreements/duties.

Failure to comply with the Plan's subrogation rules may result in termination of coverage for cause (see page 10-2), as well as legal action by the Kaiser Plan to recover benefits paid that would otherwise have been subject to recovery under the Plan's reimbursement/subrogation rights.

Section 10

When Coverage Ends

Overview

This section contains the general rules that apply when benefits under the Kaiser Plan stop for employees (active and retired) and dependents. See Continuation and Conversions, page 11-1, for specific rules governing when health care coverage stops and how it may be continued for

- surviving spouses,
- covered persons on leave of absence,
- long-term disability (LTD) beneficiaries, and
- covered members paying for coverage under temporary continued coverage.

Tip

Health care coverage may be continued in some situations. Refer to Continuation and Conversions, page 11-1, for COBRA rules. Also, special rules apply to leaves of absence for family medical care. See the Family and Medical Leave Act section of the *Sandia Employee Benefits Binder*, and page 11-3 of this SPD.

Employees (Active or Retired)

Plan benefits for active and retired employees stop on the

- Last day of the month the employee/retiree is no longer eligible (e.g., leave of absence or termination of employment), **except** as provided under temporary continuation of coverage under COBRA (see Continuation and Conversions, page 11-1);
- The later of the day of the move of residence or the date that Sandia Benefits receives written notification from an employee or retiree who changes his or her residence to beyond the Kaiser service area, provided the disenrollment form is received by Sandia Benefits within 31 calendar days of the change in residence;

  NOTE: You have the option to obtain coverage under another Sandia-sponsored medical plan, provided you notify the Sandia BCSC within 31 calendar days.

- 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 retiree becomes eligible for primary Medicare coverage.

If a member is eligible for primary Medicare coverage and resides in the KSAP Service Area, the member must enroll in the Kaiser Senior Advantage Plan.

> **NOTE:** The KSAP is available only in certain ZIP codes in California. If you live in a ZIP code area that is not covered under the KSAP, you and your covered dependents will have to disenroll from the KSAP and enroll in another Sandia-sponsored medical plan to continue coverage through Sandia.

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

Plan benefits for dependents stop on the

- date a dependent child becomes eligible for coverage as an employee under any medical plan offered by Sandia,
- last day of the month in which any cost of coverage for dependents is not paid when due,
- date employee's or retiree's coverage stops,
- last day of the month in which the dependent spouse legally divorces or separates from the employee/retiree,
- last day of the month in which a dependent child marries or ceases to be eligible under the definition of dependent, or
- last day of the month in which an employee or retiree terminates dependent coverage.

Termination by Kaiser for Cause

Kaiser may terminate your membership and the membership of your family unit (see definition in Appendix A) immediately upon written notice to you, if

- you or a member of your family unit is disruptive, unruly, or abusive to the extent that Kaiser's ability to provide services to the member or to other members is seriously impaired or you or a member of your family unit fails to establish or maintain a satisfactory doctor-patient relationship after Kaiser has made all reasonable efforts to promote such a relationship; or

- you knowingly give Kaiser incorrect or incomplete information in any document or fail to notify Kaiser of a change in your family status or Medicare coverage that may affect eligibility for membership or benefits; or
- you or a member of your family unit knowingly misrepresents membership status or coverage; or
- you or a member of your family unit knowingly presents an invalid prescription or physician order; or
- you or a member of your family unit knowingly misuses or permits the misuse of a Kaiser identification card; or
- you or a member of your family unit commits any other type of fraud in connection with your membership. Covered members terminated for cause may not be eligible for any COBRA continuation or individual conversion privileges.

Certificate of Group Health Plan Coverage

Sandia complies with the requirements of the Health Insurance Portability and Accountability Act (HIPAA), Pub. L. 104–191, which 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 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. The HIPAA provisions are designed to improve the availability and portability of health coverage not limited to the following:

- Limiting exclusions for preexisting medical conditions,
- Providing credit for prior health coverage and a process for transmitting certificates and other information concerning prior coverage to a new group health plan or issuer,
- Providing new rights that allow individuals to enroll for health coverage when they lose other health coverage or have a new dependent, and
- Prohibiting discrimination in enrollment and premiums against employees and their dependents based on health status.

When the Sandia BCSC 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, which provides proof of your prior health care 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 you enrolled in the new plan. If you become covered under another group health plan, check with the Kaiser 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.

If you do not receive a Certificate of Group Health Plan Coverage, you can obtain one by calling the Sandia BCSC within 24 months of the loss of coverage.

Section 11

Continuation and Conversions

This section outlines how coverage can be continued for you and/or your covered dependents in the event that you retire, take a leave of absence, become disabled, terminate your employment, or die.

If, for any reason, you stop active full-time or part-time work, contact Sandia Benefits [505-845-BENE (2363)] to determine what arrangements, if any, may be available for continued coverage under the Kaiser Plan. In some cases, there are special provisions for members to continue coverage. Also, Sandia abides by a federal law referred to as the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1987 in which temporary continued coverage is provided to primary participants and dependents who would otherwise lose group coverage because of specific events.

Subject to stated qualifications and requirements, coverage may be continued

- during retirement,
- during leaves of absence (LOA),
- during disability,
- for surviving spouse and dependents,* and
- for eligible persons under temporary continued coverage (COBRA).

* Surviving spouses and dependents covered under the Kaiser Plan at the time of death of the employee or retiree can continue coverage under the Kaiser Plan for the first six months at the same premium rate the retiree paid. Provided that a timely election is made (within the first six months), coverage will be continued under either the Kaiser Plan or another Sandia medical plan, whichever is applicable. (Refer to Coverage for Surviving Spouse and Dependents, page 11-4, for more information.)

1. Covered members (and their covered dependents) who voluntarily terminate Kaiser Plan coverage for themselves while still employed with Sandia, or who were terminated for cause by Kaiser, or who were terminated from Sandia for gross misconduct are not eligible for COBRA continuation or individual conversion privileges.

2. In the absence of an eligible mid-year election event or waiver of coverage due to other group health coverage, any covered members who terminate their memberships are not eligible to reenroll in the Kaiser Plan or another Sandia Medical Plan, whichever is applicable, until the next Open Enrollment period, held each fall.

During Retirement

If you retired before January 1, 1995, Sandia pays the full cost of coverage for you and your covered dependents during retirement. Sandia also pays the full cost of coverage if you retired

- between January 1, 1988, and December 31, 1994, with a service or disability pension;
- before January 1, 1988, with at least 15 years of service;* or
- between August 8, 1977, and January 1, 1988, at age 65 or older with at least ten years of service as of age 65.**

Retirees who retired with a service or disability pension after December 31, 1994, will share in the cost of coverage in the Kaiser Plan.

If you retire from Sandia but do not meet any of the above conditions, you may continue coverage under COBRA by paying the full cost of coverage. (See COBRA, page 11-5.)

NOTE: Retirees and dependents who become Medicare eligible must enroll in the Kaiser Senior Advantage Plan (KSAP). To enroll, contact Kaiser member services or the California Benefits Department, 925-294-2254.

* If you retired with a service or disability pension before August 8, 1977, with less than 15 years of service, you pay one-half the cost of coverage.

** If you retired between August 8, 1977, and January 1, 1988, with less than 15 years of service and are younger than 65 and have a service or disability pension, you pay one-half the cost of coverage.

During Leaves of Absence (LOA)

LOA for child care and family care—Sandia pays the employer portion of the premium for the Plan for the first six months. For active employees, see detailed information in your Sandia Employee Benefits Binder under Family Medical Leave Act. Employees who remain on LOA beyond six months must pay the full cost of coverage to continue their medical benefits.

LOA to the Military—Sandia pays the employer portion of the premium for the Plan for the first six months. Employees who remain on LOA beyond six months must pay the full cost of coverage to continue their medical benefits.

All other LOAs—Coverage stops at the end of the month in which the LOA begins. Coverage may be continued by paying the full premium for the length of the LOA.

If you continue coverage under a Leave of Absence, this time counts toward temporary continued coverage under COBRA.

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 11-5. 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.**

During Disability

Employees disabled after January 1, 1982, and before retirement (disability terminees) who are eligible to receive benefits from the Sandia Long-Term Disability (LTD) Plan will have coverage continued until the end of the month in which the

- LTD recipient recovers and benefits cease,
- LTD benefits cease for any reason, or
- LTD recipient dies.

Tip **Contact the Sandia BCSC at 505-845-BENE (2363) if you have questions.**

Covered LTD participants eligible for primary Medicare coverage must enroll in Medicare Parts A and B and the KSAP to continue coverage through Sandia. Coverage will be provided under the Kaiser Senior Advantage Plan (KSAP). As soon as you become eligible for primary Medicare coverage, you need to contact the California Benefits Department to enroll in the KSAP.

Coverage for Surviving Spouse and Dependents

The following table contains the terms of the Kaiser Plan coverage for the surviving spouse and dependents at the time of death of on-roll regular employees and most retirees.

When a surviving spouse or dependent child is or becomes Medicare primary eligible during the first six months after the employee's or retiree's death, coverage under the Kaiser Plan will terminate, and the spouse or dependent child must enroll in the KSAP for the remainder of the six months. If a survivor becomes Medicare primary eligible and has coverage through the Kaiser Plan after the first six months, the survivor must enroll in the KSAP.

Coverage	Surviving Spouse and Dependents	Dependent Children with No Surviving Parent
First six months	Employer portion of the premium is paid for by Sandia.	Employer portion of the premium is paid for by Sandia.
	EXCEPTION **Premiums for the first six months of coverage for survivors of those retired employees paying their own premiums at the time of death are NOT paid for by Sandia.**	
Continued coverage	May continue coverage for life if elected in the first six months after employee's or retiree's death. Survivors pay one-half of the cost of monthly premium coverage.	Option to purchase up to an additional 30 months of coverage through COBRA.

Special Rules

- All Class I dependents covered at the time of death of the employee or retiree are eligible.
- No new dependents can be added unless a qualifying COBRA event occurs within the first 36 months after the member's death. (Temporary continued coverage is explained under COBRA, page 11-5.)
- The first six months of coverage and any continued coverage for surviving spouses count toward the temporary continued coverages explained under COBRA, page 11-5.

Termination Rules

For the surviving spouse and dependents, coverage terminates if

- the spouse remarries — if remarriage occurs less than 36 months after the employee's death, the spouse may have rights under COBRA (see section below),
- payments are not received when due, or
- a surviving spouse dies — if death occurs less than 36 months after the employee or retiree has died, dependents may have rights under COBRA (see section below).

COBRA

A federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA) became effective January 1, 1987. This law requires Sandia to offer a temporary extension of health care coverage to primary members and dependents who would otherwise lose their group health coverage as a result of certain events (see Events Causing Loss of Coverage, page 11-6).

Although not required under federal law – the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – effective July 1, 2003, Sandia will extend continuation coverage to domestic partners, and/or domestic partner's children. They may be eligible to continue health coverage for a limited time, if applicable, when eligibility for group coverage as a dependent is lost because of a qualifying event.

The cost of continued coverage is paid by the member at the applicable group rate plus a 2% administrative fee.

> **NOTE:** If you lost Plan coverage because of termination of employment and you are or become disabled and are not eligible for long-term disability benefits or a service or disability pension, you will be charged 150% of the applicable group rate after the first 18 months. See page 11-6.

Qualified beneficiaries under COBRA include

- you (the employee or retiree),
- your dependents (spouses, children, domestic partners, and domestic partner dependents)

if covered under this Plan the day before the events causing loss of coverage.

In addition, a qualified beneficiary under COBRA also includes a child born to or placed for adoption with a covered employee or retiree during the period of the

employee's or retiree's continuation coverage. Newborn children or adopted children need to be enrolled in the Kaiser Plan within 31 calendar days from their date of birth, adoption, or placement for adoption, whichever is applicable. Once the newborn or adopted child is enrolled in continuation coverage pursuant to Kaiser Plan rules, the child will be treated like all other COBRA qualified beneficiaries.

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

Covered persons terminated for cause by Kaiser or by Sandia for gross misconduct are not eligible for any COBRA continuation or individual conversion privileges.

If a COBRA participant moves out of the Kaiser network service area, the participant will be offered another applicable medical plan offered by Sandia.

Events Causing Loss of Coverage

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

If you are the . . .	and if you, the covered member, lose Kaiser coverage because of . . .	then, under COBRA you have the right to choose temporary continued coverage for a maximum of . . .
employee, dependents (spouses, children, domestic partners, and domestic partner dependents)	■ a reduction in the number of hours of employment at Sandia, ■ termination of employment,	18 months.
employee, dependents (spouses, children,	■ termination of employment, and you are disabled or become disabled within the first 60 days of COBRA coverage	29 months.

If you are the . . .	and if you, the covered member, lose Kaiser coverage because of . . .	then, under COBRA you have the right to choose temporary continued coverage for a maximum of . . .
domestic partners, and domestic partner dependents)	as determined by Social Security, and you lack Medicare coverage,*	**NOTE:** After the first 18 months, you will be charged 150% of the cost of the regular premium.
spouse	■ the death of the Sandia employee or retiree (see Coverage for Surviving Spouse and Dependents, page 11-4), ■ a divorce or legal separation from a Sandia employee/retiree	36 months.
dependent child	■ the death of a Sandia employee or retiree, ■ a divorce or legal separation of your parents, ■ a change in eligible status (i.e., dependent ceases to be a dependent child under Kaiser, such as stepchildren of divorced parents, eligible dependent of surviving spouse who dies, or a child who turns 24),	36 months.
domestic partner and/or domestic partner dependents	■ the Sandia employee's retirement, ■ the death of the Sandia employee, ■ the end of a domestic partnership.	36 months.

IMPORTANT **Additional events, such as death, divorce, legal separation, or Medicare entitlement, that occur during the initial 18-month period or during disability extension may extend the COBRA period to 29 or 36 months for qualified beneficiaries, but in no event will coverage extend beyond 29 or 36 months after the initial qualifying event. Sandia must be notified of the second qualifying event within 60 days in order for the COBRA participant to be eligible for the extension.**

Notification and Election of COBRA

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

*You must notify the Sandia BCSC at 505-845-BENE (2363) within 60 days of the date Social Security determines that you or a family member is disabled and within the first 18 months of COBRA continuation of coverage.

Step	Who	Action
1	Employee or family member	Notify Sandia BCSC in writing at P. O. Box 5800, Albuquerque, NM 87185-1022 within 60 days* of ■ divorce, ■ legal separation, ■ loss of a child's dependent status, ■ disability designation by Social Security, ■ death of a primary covered participant other than an employee, or ■ domestic partner relationship ends.
2	BCSC	Notify Sandia COBRA Administrator of covered participant's ■ death or ■ termination of employment or loss of eligibility.
3	Sandia COBRA Admin-istrator	Notify participants that they have the right to choose continued coverage within 60 days from the latest of the following dates: ■ receipt of notification by Sandia BCSC or ■ when coverage actually ends.
4	Covered participant	Contact the COBRA Administrator at Sandia to elect COBRA coverage. ■ Covered participant has 60 days to elect COBRA from 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 and a 30-day grace period every month thereafter.
		■ **If you elect continued coverage**, then Sandia provides coverage under the Kaiser Plan **at your expense** plus the applicable administrative fee. **NOTE:** See Coverage for Surviving Spouse and Dependents, page 11-4. **If you do not elect continued coverage,** then group coverage under the Kaiser Plan ends.

The following benefits apply to COBRA participants:

- A qualified beneficiary is entitled to the same coverage as he/she had before the mid-year change event.
- A qualified beneficiary has the same open enrollment period rights as similarly situated active employees.

*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.

- If coverage is modified for similarly situated active employees, the coverage to COBRA beneficiaries is modified in the same manner.
- If the employer discontinues the plan or benefit package under which the qualified beneficiaries were receiving benefits, they must still be able to receive different employer-provided coverage.
- Qualified beneficiaries receiving COBRA coverage have the same right to enroll family members, under HIPAA special enrollment rules, as active employees and Plan participants do.
- If a COBRA participant moves out of the service area, the participant will have the same coverage available to other insureds living out of the service area.

Termination of Temporary Coverage

Temporary continued coverage under the Kaiser Plan may be terminated before 18, 29, or 36 months of coverage when

- Sandia no longer provides coverage to any employee.
- the premium for continued coverage is not paid within the grace period.
- you become covered under any other type of group health plan. If that group plan has an exclusion or limitation regarding preexisting conditions, the covered member can continue to purchase temporary continued coverage to obtain coverage for your preexisting condition. However, the other group health plan would provide your primary coverage; the KHP would provide only secondary coverage.

Coverage extension required under other laws (e.g., state law) or provided by other provisions of this Plan, such as leaves of absence or for surviving spouses, continue concurrently with (i.e., count toward) temporary continued coverage available under COBRA.

Conversion Privileges

Converting to Individual (Conversion) Plan Coverage

If you cease to qualify as a covered member or an eligible dependent and you are no longer covered by or eligible for group coverage, you may be eligible to convert to an individual Plan. If so, you may continue your KHP membership with no lapse in coverage by applying to a Kaiser Member Services office (800-464-4000) within 63 days of the date of Kaiser's termination letter, or of your group coverage termination date, whichever date is later. You will have to

pay dues, and the benefits and copayment under the new coverage may differ from those under the previous group coverage plan.

If you do not convert to individual membership, your coverage will end at the end of the last month for which you are eligible for group coverage. Kaiser will charge nonmember rates for any services that you receive after that date.

Enrollment in Kaiser Permanente Individual Plan

A person may enroll in Personal Advantage, individual and family coverage, by submitting a completed medical review questionnaire for each applicant and an application for membership on forms provided by the KHP. Written notice of acceptance or rejection is provided to the applicant. The application review usually takes six to eight weeks. If the applicant(s) qualify, coverage is effective on the date specified in KHP's notice of acceptance, subject to payment of the monthly charge.

Ineligible Members

If Kaiser terminates your membership or the membership of anyone in your family unit for cause or for nonpayment, the individuals in your family unit will not be eligible to convert to the federally qualified individual Plan membership or to enroll in any other Kaiser Permanente coverage or in any plan that offers services through Kaiser Permanente.

Continuation of Coverage for Totally Disabled Persons

If you become totally disabled after January 1, 1977, while you are a Kaiser Permanente member in the northern California region, and your group service agreement terminates, coverage for your disabling condition will continue for 12 months or until you are no longer disabled or until Kaiser's contract with your group is replaced by another group health plan without a limitation on the disabling condition, whichever occurs first. Such care is subject to the terms of this coverage including copayments.

Appendix A

Acronyms and Definitions

Acronyms

BCSC	Sandia Benefits Customer Service Center
CMS	Centers of Medicare & Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
DAB	Department Appeals Board
DOC	California Department of Managed Health Care
DMHC	(California) Department of Managed Health Care
EBC	Employee Benefits Committee
EOC	Kaiser's Evidence of Coverage
ERISA	Employee Retirement Income and Security Act
FICA	Federal Insurance Contributions Act
FMLA	Family and Medical Leave Act
HIPAA	Health Insurance Portability and Accountability Act
HMO	health maintenance organization
ID	identification

KHP	Kaiser Health Plan
KSAP	Kaiser Senior Advantage Plan
LOA	leave of absence
LTD	long-term disability
PHS	Public Health Service (Act)
POS	Point-of-Service (Plan)
PPO	Preferred Provider Organization
PRO	Peer Review Organization
PTPP	Pre-Tax Premium Plan (see definition)
RSA	Reimbursement Spending Account
SNL	Sandia National Laboratories
SPD	Summary Plan Description

Definitions

child

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

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

See Eligible Dependents, page 3-4, for an explanation of children to be covered by the Kaiser Plan.

CMS

The Centers of Medicare & Medicaid Services (formerly known as the Health Care Financing Administration) is a federal agency that administers the Medicare program.

COBRA	The federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1987 requires Sandia to offer a temporary extension of health care coverage to primary insureds and dependents who would otherwise lose their group health coverage as a result of certain events (see Events Causing Loss of Coverage, page 11-6). The cost of continued coverage is paid by the insured at the applicable group rate plus a 2% administrative fee.
copayment	Any amount charged to a member at the time of service for covered services.
copayment limit	Limit on the amount of copayments due in a calendar year.
dependent	Any eligible member of a subscriber's family who is enrolled and for whom prepayment has been received.
dual Sandians	Both spouses are employed by or retired from Sandia National Laboratories.
family unit	A subscriber and all of his or her enrolled family dependents.
financially dependent persons	Persons who receive more than 50% of their support from the primary subscriber.
Health Care Reimbursement Spending Account	Pre-tax money that is set aside to help pay for health care expenses not reimbursed or only partially reimbursed by any medical, dental, or vision plan or other health insurance plan. This account can be used by active employees only.

hospice	A program provided by a licensed facility or agency that provides home health care, homemaker services, emotional support services, and other services provided to a terminally ill person whose life expectancy is six months or less as certified by the person's physician.
KHP	The Kaiser Health Plan (KHP) Medical Care Program, composed of Kaiser Foundation Health Plan, Inc. (Health Plan), Kaiser Foundation hospitals, and the Permanente Medical Group, Inc.
Medical Group	The Kaiser Permanente Medical Group, Inc.
Medicare	A medical program administered by the Social Security Administration that provides benefits partially covering the cost of necessary medical care.
member	Any subscriber or enrolled family dependent.
nonmember rate	A fee charged when services are provided to nonmembers or to members when they are not covered for that specific service.
Open Enrollment period	The period of time every year when you may select your medical coverage for the subsequent calendar year.
out-of-pocket maximum	The member's financial responsibility for covered medical expenses for that calendar year.
Plan	Kaiser Health Plan (KHP)
Plan documents	Plan documents include the following: ■ Summary Plan Description (SPD), ■ Summary Annual Reports (SARs), ■ Administrative Manual, ■ Copies of annual reports (5500s) and supporting financial reports and statements (Schedule A), and ■ Kaiser Group Agreement.

post-secondary education program	Junior college, college, or university education programs (they do not apply to high school students).
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, survivor, or the individual who is purchasing temporary continued coverage.
Peer Review Organization	A group of doctors paid by the federal government to review the medical necessity, appropriateness and quality of hospital treatment furnished to you and/or to monitor the quality of care provided to Medicare beneficiaries.
qualified beneficiary	An employee, spouse, or dependent covered the day before the qualifying event, including 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.
qualifying event	Under COBRA, an event that but for the COBRA requirements would result in the loss of coverage to a qualified beneficiary.
Qualified Medical Child Support Order	A judgment, decree, order, or property settlement agreement issued either by a court of competent jurisdiction or through an administrative process established under state law. The administrative process must have the force and effect of law in that state in connection with state domestic relation law that enforces certain laws relating to medical child support.
Sandia-sponsored medical plans	Top PPO, Intermediate PPO, Basic PPO, CIGNA Network POS Plan, KHP HMO, Lovelace Senior Plan (LSP), and Kaiser Senior Advantage Plan (KSAP).

service agreement — The Group Medical and Hospital Service Agreement between KHP and Sandia National Laboratories.

service area — The geographical area designated by Kaiser within the following 15 northern California counties: Alameda, Amador, Contra Costa, El Dorado, Fresno, San Joaquin, San Mateo, Santa Clara, Solano, Sonoma, Sutter, Stanislaus, Tulare, Yolo and Yuba. Also includes partial counties designated by specific ZIP codes.

subrogation — Kaiser's right to recover any Plan costs and payments made because of an illness or injury to you or your covered dependent 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 recovered payments from the third party.

subscriber — A member who is eligible for membership on his or her own behalf through a relationship to group coverage and who meets eligibility requirements.

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.

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Appendix B

Health Insurance Portability and Accountability Act of 1996

A federal law, the Health Insurance and Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of private health information. A complete description of your rights under HIPAA will be mailed to you by April 14, 2003, from Kaiser.

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 has required 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.

Kaiser maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. Privacy notices will be distributed to all current enrollees in the Plan by April 14, 2003, and to new primary participants upon enrollment in the Plan. In addition, a copy of this notice will be available upon request by contacting the Kaiser Member Services Department. If you have questions about the privacy of your health information or you wish to file a complaint under HIPAA, please contact the Kaiser Member Services Department.

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