



April 2007

Dear UHC High Deductible Health Plan (HDHP) PPO Plan Participant:

Our records show that you are enrolled in the UnitedHealthcare (UHC) HDHP PPO. The following are modifications and clarifications that are effective January 1, 2007 unless otherwise stated. These modifications and clarifications are referred to as a Summary of Material Modifications (SMM) and are intended as a summary to supplement the Summary Plan Description, effective January 1, 2006, and are a part of the official plan document. It is important that you keep this summary with your SPD since this material plus the SPD comprise your complete SPD. In the event of any discrepancy between this Summary of Material Modifications (SMM) and the SPD, the provisions of this SMM shall govern.

Effective in 2006:

| Section 5: Coverage/Limitations | | |
|---------------------------------|---------------------------------|--|
| Pages: | Under Heading: | The Following Should be Noted: |
| 5-21 | Immunizations/Flu Shot Services | <p>Delete the sentence: The Plan will pay 100% of the eligible expense in-network and 70% of the eligible expense, after the deductible, if done out-of-network for flu shots, pneumococcal vaccine, and immunizations related to personal travel.</p> <p>Replace with: The Plan will pay 100% of the eligible expense in-network and 70% of the eligible expense, after the deductible, if done out-of-network for immunizations (effective 1/1/06), flu shots, pneumococcal vaccine, and immunizations related to personal travel. Shingles vaccine is a covered benefit for members 60 and over (effective 5/26/06). The human papilloma virus (HPV) vaccine is a covered benefit for covered female members age 9-25 (effective 8/06). The HPV vaccine is limited to one complete dosage per lifetime.</p> |

Effective January 1, 2007:

| Entire SPD | | |
|--|--|--|
| The Following Should be Noted: | | |
| Replace all references of Care Coordination SM to Personal Health Support | | |
| Replace all references of a UHC Nurse to a Personal Health Support Nurse | | |

| Section 1: Eligibility | | |
|------------------------|--|--|
| Pages: | Under Heading: | The Following Should be Noted: |
| 2-1 to 2-8 | Section 2: Enrollment and Disenrollment | Replace 31 calendar days to 90 calendar days for enrollment due to birth |

| Section 5: Coverages/Limitations | | |
|----------------------------------|---------------------------------|--|
| Pages: | Under Heading: | The Following Should be Noted: |
| 5-21 | Immunizations/Flu Shot Services | <p>Delete the following: If you are unable to obtain the type of immunization required at the physician's office (e.g. malaria pills) in Albuquerque, New Mexico, you can go to Concentra, 3800 Commons NE (505-822-9480) and receive in-network benefits. If you need different types of immunizations for personal travel where at least one of these is not available at a physician's office, you may obtain all of your immunizations at Concentra. If you are located anywhere else in the United States, contact UHC customer service at 1-877-835-9855.</p> <p>Replace with: If you are unable to obtain the type of immunization required the physician's office (e.g. malaria pills), contact UHC customer service at 1-877-835-9855 to request a network gap exception.</p> |

| Section 13: Health Savings Account | | |
|------------------------------------|------------------------|---|
| Pages: | Under Heading: | The Following Should be Noted: |
| 13-2 | HSA Contributions | <p>Limits for contributions for 2007 are \$2,850 for single coverage and \$5,650 for family coverage.</p> <p>Participants who enroll in this Plan and become eligible for HSA contributions in the middle of the year can make contributions up to the full annual limit, as long as they are eligible in December of that year and remain eligible for the HDHP for the next 12 months.</p> |
| 13-3 | Opening an HSA Account | <p>The account balance necessary for inclusion in the investment program will increase from \$1,000 to \$2,000. Funds that have already been invested will not be impacted but future investments can only be made after the \$2,000 minimum balance is met. Once the minimum balance is met, account holders can continue to invest in Exante's mutual fund options in increments of as little as \$100.</p> |

Appendix C: UHC HDHP Acronyms and Definitions

| Pages: | Under Heading: | The Following Should be Noted: |
|--------|-------------------|---|
| C-6 | Eligible Expenses | <p>Delete the following: Charges for Covered Health Services that are provided while the plan is in effect, determined as follows:</p> <ul style="list-style-type: none"> - in-network benefits – contracted rates with the provider - out-of-network benefits: <ul style="list-style-type: none"> o Selected data resources which, in the judgment of the Claims Administrator, represent competitive fees in that geographic area or o Negotiated rates agreed to by the out-of-network provider and either the Claims Administrator or one of its vendors, affiliates, or subcontractors <p>These provisions do not apply if you receive covered health services from an out-of-network provider in an emergency. In that case, eligible expenses are the amounts billed by the provider, unless the Claims Administrator negotiates lower rates. Eligible expenses are subject to the Claims Administrator’s reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from the Claims Administrator.</p> <p>Replace with: Charges for Covered Health Services that are provided while the plan is in effect, determined as follows:</p> <ul style="list-style-type: none"> - In-network benefits – contracted rates with the provider - Out-of-network benefits: <ul style="list-style-type: none"> o Negotiated rates agreed to by the out-of-network provider and either the Claims Administrator or one of its vendors, affiliates, or subcontractors o The following: <ul style="list-style-type: none"> ▪ Selected data resources which, in the judgment of the Claims Administrator, represent competitive fees in that geographic area; ▪ Fees that are negotiated by with the provider; ▪ XX% of the billed charge; or ▪ A fee schedule that the Claims Administrator develops. <p>For certain Covered Health Services, you are required to pay a percentage of Eligible Expenses in the form of coinsurance.</p> <p>These provisions do not apply if you receive covered health services from an out-of-network provider in an emergency. In that case, eligible expenses are the amounts billed by the provider, unless the Claims Administrator negotiates lower rates. Eligible expenses are subject to the Claims Administrator’s reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from the Claims Administrator.</p> |



Sandia National Laboratories

UnitedHealthcare (UHC) High Deductible Health Plan

Summary Plan Description

Effective: January 1, 2006

UnitedHealthcare (UHC) High Deductible Health Plan

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

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

The **UHC HDHP** is a self-insured plan for eligible members and is sponsored and maintained by Sandia Corporation, 1515 Eubank SE, Albuquerque, NM, 87123 (employer identification number 85-0097942, plan number 519). This Plan is administered on a calendar-year basis, from January 1 through December 31, for accumulation of maximums, **deductibles**, claim filing, and filing of reports to the Department of Labor. **UHC**, the **claims administrator**, has assigned Sandia group plan number **708576**. For information concerning service of legal process, contact the Sandia Legal Division, Sandia National Laboratories, 1515 Eubank SE, MS0141, Albuquerque, NM 87123.

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

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

The **UHC HDHP** is maintained at the discretion of Sandia and is not intended to create a contract of employment and does not change the at will employment relationship between you and Sandia. The Sandia Board of Directors (or designated representative) reserves the right to change or amend any or all provisions of the **UHC HDHP**, and to terminate the **UHC HDHP** at any time without prior notice, subject to applicable collective bargaining agreements. If the **UHC HDHP** 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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Section 1. Eligibility

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

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

The following groups are eligible to enroll in this Plan:

- retirees not eligible for primary **Medicare** coverage
- long-term disability terminatees not eligible for primary Medicare coverage
- surviving spouses not eligible for primary **Medicare** coverage

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

Important

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

Retirees

Covered members who retire and are not eligible for **Medicare primary** coverage may be eligible for coverage under this Plan. If you elect to enroll in this Plan, this Plan will continue to be your primary coverage as long as you remain enrolled and until such time you become eligible for **Medicare primary** coverage. Refer to Section 12, Continuation of Group Health Coverage, for more information.

Note: Retirement from Sandia is a **mid-year election change event**. You may be able to select any of the applicable plans under the Retiree Medical Plan Option if you enroll in the new medical plan within 31 calendar days of the date you retire.

Note: When you or any of your dependents turn 65, the Sandia Benefits office will send you a courtesy letter informing you of the opportunity to enroll in **Medicare** and of the medical plan options available to you. However, if you do not receive this letter, it does not relieve you or your covered dependents of the responsibility for enrolling in **Medicare** Parts A and B to receive full benefits.

If you are currently a retiree who is not eligible for primary **Medicare** coverage, this Plan is available as an option during the **open enrollment** period Sandia holds during the fall every year to you and your covered dependents who are not eligible for primary **Medicare** coverage. Contact Sandia **HBES** to learn about options available to you and your covered dependents.

Long-Term Disability Terminees

Covered members who may continue coverage under this plan if, after January 1, 1982, they:

- became disabled before retirement, and
- have been approved for and are receiving long-term disability benefits under the Sandia Long-Term Disability Plan or the Sandia Long-Term Disability Plus Plan, and
- are enrolled in this Plan, and
- are not eligible to have **Medicare** as their primary coverage.

If you elect to remain enrolled in this Plan, it will continue to be your primary coverage so long as you remain enrolled and until such time that you become eligible for **Medicare primary** coverage. Refer to Section 12, Continuation of Group Health Coverage, for more information.

Note: Terminating from Sandia is a *mid-year election change event*. You may be able to select any of the applicable *plans* under the Long-Term Disability Medical Plan Option if you enroll in the new medical plan within 31 calendar days of the date you terminate.

If you are currently a *long-term disability terminnee* who is not eligible for primary *Medicare* coverage, this Plan is available as an option during the *open enrollment* period Sandia holds during the fall every year to you and your covered dependents who are not eligible for primary *Medicare* coverage. Contact Sandia *HBES* to learn about options available to you and your covered dependents.

Other Eligible Persons

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

- Surviving spouse (who is not eligible for *Medicare primary* coverage) of a regular Sandia employee or retiree. Refer to Section 12, Continuation of Group Health Coverage, for more information.

Eligible Dependents

Eligible plan dependents are those individuals who are dependents of a *primary covered member* and any *child* of a *primary covered member* who is recognized as an *alternate recipient* in a *Qualified Medical Child Support Order (QMCSO)*.

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

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

Important

As an employer, Sandia is obligated to accurately withhold income and employment taxes. If your Plan dependent does not qualify as a tax dependent under **IRC** Section 152 for purposes of health care coverage for the entire year, you may be subject to imputed income. Refer to Section 3, Group Health Plan Premiums, for more information.

Class I Dependents

Your Class I dependents who are eligible for coverage under this Plan include dependents who are not eligible for primary **Medicare** coverage (unless otherwise noted in Eligible Dependents above) and include your:

- Spouse, not legally separated or divorced from you

Note: An annulment also makes the spouse ineligible for coverage.

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

Class II Dependents

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

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

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

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

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

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

Qualified Medical Child Support Order

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

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

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

Eligibility Appeal Procedures

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

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

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

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

Note: If you do not enroll a dependent because the dependent has other medical coverage and your dependent involuntarily loses eligibility for that coverage, you may be able to enroll the dependent in your medical plan provided that you enroll your dependent within 31 calendar days after the other coverage ends. Refer to **HIPAA** Rights, page 2-6.

Section 2. Enrollment and Disenrollment

This section outlines the enrollment procedures for retirees, survivors and long-term disability terminees; enrolling and disenrolling dependents, and the consequences of not disenrolling dependents in a timely manner. It also provides information on your enrollment rights under the Health Insurance Portability and Accountability Act (*HIPAA*) of 1996 and the option to waive or drop coverage. For the events that may allow you to make a mid-year election change, see the *Pre-tax Premium Plan* booklet.

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

Retirees and LTD Terminees

To enroll in the *UHC* High Deductible Health Plan (outside the **open enrollment** period Sandia holds in the fall):

- Upon becoming eligible for coverage under this Plan, complete the medical enrollment form and keep a copy as proof of coverage until you receive your identification (**ID**) card(s) from the **claims administrator**.
- Mail the form, early enough to meet the 31-calendar-day criteria, to Sandia **HBES**, P.O. Box 5800, Albuquerque, NM, 87185, MS1022.

Refer to Section 12, Continuation of Group Health Coverage, for information on enrollment for survivors.

Enrolling Dependents

Important

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

Enrolling Class I Dependents

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

Important

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

To enroll Class I dependents in the **UHC** High Deductible Health Plan:

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

Note: Refer to Section 3, Group Health Plan Premiums, for information on whether your dependent qualifies for pre-tax health benefits.

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

Important

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

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

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

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

Enrolling Class II Dependents

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

Important

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

To enroll Class II dependents in the **UHC** High Deductible Health Plan:

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

Note: Refer to Section 3, Group Health Plan Premiums, for information on whether your dependent qualifies for pre-tax health benefits.

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

Important

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

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

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

| Class II Dependent | Effective Date of Coverage |
|---|---|
| Unmarried child or stepchild | Later of the date of the event creating eligibility or the date Benefits receives completed paperwork |
| Unmarried grandchild | Later of the date of the event creating eligibility or the date Benefits receives completed paperwork Note: If eligible due to birth or adoption or placement for adoption, the effective date is the date of the event. |
| Unmarried brother or sister | Later of the date of the event creating eligibility or the date Benefits receives completed paperwork |
| Your or your spouse's parent, step-parent, or grandparent | Later of the date of the event creating eligibility or the date Benefits receives completed paperwork |

Disenrolling Dependents

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

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

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

Note: You can disenroll your dependents at any time without a mid-year election change event; however, you can only reenroll them with a mid-year election change event or during open enrollment.

Events Causing Your Dependent to Become Ineligible

Your dependents become ineligible and you must disenroll them when one or more of the following events occur:

Class I:

- Divorce or annulment
- Legal separation
- **Child** marries
- **Child** is no longer financially dependent
- **Child** no longer meets the age criteria
- Incapacitated **child** no longer meets incapacitation criteria
- **Child** is no longer covered under a **QMCSO**

Class II:

- **Child**, step-child, grandchild, brother, or sister marries
- **Child**, step-child, grandchild, brother, sister, parent, step-parent, or grandparent no longer meets Class II eligibility requirements criteria

How to Disenroll Dependents

- Complete the dependent disenrollment form (SF 4400 DIS)

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

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

Important

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

Forms are available by calling Sandia **HBES** at (505) 844-4237.

Sandia abides by a federal law referred to as the Consolidated Omnibus Budget Reconciliation Act (**COBRA**) of 1985 in which temporary continued coverage is provided to dependents who would otherwise lose group coverage due to specified events. Refer to Section 12, Continuation of Group Health Coverage, for more information.

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

Consequence of Not Disenrolling Ineligible Dependents

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

If you do not disenroll your ineligible dependents, Sandia may:

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

If you do not disenroll your ineligible dependents, Sandia will:

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

HIPAA Rights

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

These events include:

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

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

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

Important

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

Waiving or Dropping Coverage in Sandia-Sponsored Medical Plans

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

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

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

Important

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

How to Waive or Drop Coverage

- Complete the waiver of medical coverage form (SF 4811-WMC)
- Retain a copy for your files
- Mail the original to Sandia **HBES** at Mail Stop 1022

Forms are available by calling the Sandia **HBES** at (505) 844-4237.

Mid-Year Election Change Events

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

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

Section 3. Group Health Plan Premiums

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

Important

*Benefits paid under a group health plan for your covered dependents who would not qualify as a tax dependent under the **IRC** for purposes of health care coverage will cause the **primary covered member** to receive additional compensation as taxable wages. The **primary covered member** is required to declare as taxable income the value of the coverage for the non-eligible dependent. Imputed income is not a pay increase. It is the value of Sandia's contributions for health coverage for dependents that are not your tax dependents. The imputed income may be subject to income taxes. This amount will be reported on the appropriate reporting tax form.*

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

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

Important

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

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

Monthly Premium Payment for Coverage

In most instances, Sandia requires a monthly premium payment for coverage of eligible individuals under this Plan. If you are required to pay a premium, the monthly premium share amount will be deducted from your monthly pension check.

Survivors have the option of paying the monthly premium share amount:

- From their monthly pension check
- Directly from their bank account
- In a direct payment to Sandia

Other eligible covered persons pay:

- In a direct payment to Sandia

Note: Certain health care premiums are not eligible for reimbursement under the health savings account. See Section 13 for more information.

Premium for Retiree Medical Plan Option

The retiree premiums for continued health care coverage under this Plan are provided during the *open enrollment* period Sandia holds each fall. Retirees may also contact Sandia *HBES* at (505) 844-4237 for premium rates.

Sandia pays the full amount of coverage for you and your covered dependents during retirement if you retired with a service pension as follows:

- Between August 8, 1977, and January 1, 1988, at age 64 or older, with at least 10 years of service as of age 65, or
- Before January 1, 1988, with at least 15 years of service, or
- Between January 1, 1988, and December 31, 1994, with a service or disability pension

Retirees who retired with a service or disability pension after December 31, 1994, will share in the cost of coverage in this Plan. The current cost-sharing is as follows:

- Retirees who retired after December 31, 1994, and before January 1, 2003, will pay 10% of the full experienced-rated premium.
- Retirees who retired after December 31, 2002, will pay a percentage of the full experienced-rated premium based on their *term of employment* as follows:
 - 30+ years – 10%
 - 25-29 years – 15%
 - 20-24 years – 25%

- 15-19 years – 35%
- 10-14 years – 45%

Retirees who do not meet any of the above conditions may continue coverage under this Plan by paying the full cost of coverage under **COBRA**. Refer to Section 12, Continuation of Group Health Coverage, for more information.

Dual Sandians

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

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

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

Class II Dependent Premium

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

Premium for Long-Term Disability (LTD) Terminee Medical Plan Option

The premiums for continued health care coverage for ***long-term disability terminees*** under this Plan are provided during the ***open enrollment*** period Sandia holds each fall. LTD terminees may also contact Sandia ***HBES*** at (505) 844-4237 for premium rates.

If you became an LTD terminnee before January 1, 2003, you pay 10% of the full experience-rated premium for you and your covered dependents.

If you became an LTD terminnee after December 31, 2002, you pay 35% of the full experience-rated premium for you and your covered dependents.

Refer to Section 12, Continuation of Group Health Coverage, for more information.

Premium for Surviving Spouse Medical Plan Option

As a survivor of a regular Sandia employee or retiree, you are eligible for continuation of coverage under the Surviving Spouse Medical Plan Option by paying the applicable monthly premium.

Important

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

The survivor premium payments for the first six months will be at the rate the employee or retiree was paying for coverage at the time of death. After the initial six months, the survivor (and any dependents enrolled at the time of death) may continue coverage by paying:

- 50% of the full experienced-rated premium if you are a survivor of a retiree or a regular employee with 15 years or more ***term of employment***
- 100% of the full experienced-rated premium if you are a survivor of a regular employee with less than 15 years of ***term of employment***.

Your decision for continuation of coverage under the Surviving Spouse Medical Plan Option must be made prior to the expiration of the initial six-month coverage. The applicable survivor rate will depend on the health care plan under which you are covered and whether coverage is for single or family coverage. Refer to Section 12, Continuation of Group Health Coverage, for more information.

Section 4. Deductibles and Maximums

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

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

Deductibles

The member must first pay the annual *deductible* before the Plan begins to pay for covered health care services. When the member meets the full *deductible* amount, the Plan begins to pay for eligible, covered expenses at the applicable *coinsurance* amount. However, if utilizing in-network providers, the Plan will reimburse certain covered preventive health services at 100% of *eligible expenses*, with no *deductible* required.

| General Information | In-Network Option | | Out-of-Network Option | |
|---------------------|-------------------|-----------------------|-----------------------|-----------------------|
| | Individual | Family of two or more | Individual | Family of two or more |
| Annual Deductible | \$1,200 | \$2,400 | \$2,000 | \$4,000 |

Payments Not Applied to Deductible

Amounts above *eligible expenses*, charges not covered by the Plan and charges incurred because of failure to obtain required *pre-certifications* or *prior notifications* do not apply toward the *deductible*.

Family Deductible

Although each family member may contribute toward the family *deductible* based on their individual Plan usage, individual contribution maximums are equivalent to the family *deductible* amount. In other words, if only one family member is incurring expenses under the plan, that individual must incur the full family deductible before the plan begins to cover eligible expenses.

Example: A retiree has coverage consisting of himself and his spouse. The in-network *deductible* for this family is \$2,400. During the calendar year, the couple incurred in-

network expenses of \$1,500 each (all non-preventive). These expenses are determined to be covered charges and are applied to the *deductible* by the *claims administrator* in the order of receipt of the claims. The individuals contribute to the *deductible* as follows:

| In-Network Deductible Example | | | |
|-------------------------------|-------------------|-----------------------|-----------------------|
| | Expenses Incurred | Individual Plan Limit | Applied to Deductible |
| Retiree | \$1,500 | \$1,200 | \$1,200 |
| Spouse | \$1,500 | \$1,200 | \$1,200 |
| Total: | | | \$2,400 |

In this example, the family *deductible* has been met in-network.

Example: A retiree has coverage for herself and her spouse. The in-network *deductible* for this family is \$2,400. During the calendar year, the retiree incurred in-network expenses of \$2,000 (all non-preventive) while her spouse incurred none. These expenses are determined to be covered charges and are applied to the *deductible* by the *claims administrator* in the order of receipt of the claims. The couple contributes to the *deductible* as follows:

| In-Network Deductible Example | | | |
|-------------------------------|-------------------|-----------------------|-----------------------|
| | Expenses Incurred | Individual Plan Limit | Applied to Deductible |
| Retiree | \$2,000 | \$1,200 | \$2,000 |
| Spouse | \$0 | \$0 | \$0 |
| Total: | | | \$2,000 |

In this example, the retiree has not met her family *deductible*. The Plan will not begin to cover *eligible expenses* (other than preventive) for her or her spouse until she or her spouse incurs another \$400 in expenses.

Out-of-Pocket Maximums

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

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

- For the member: when a member uses the in-network option and has incurred the in-network, *out-of-pocket maximum* for covered medical expenses
- For a retiree with family coverage: when a family uses the in-network option and has incurred their in-network, *out-of-pocket maximum* for covered medical expenses
- For the member: when a member uses the out-of-network option and has incurred the out-of-network, *out-of-pocket maximum* for covered medical expenses
- For a retiree with family coverage: when a family uses the out-of-network option and has incurred their out-of-network, *out-of-pocket maximum* for covered medical expenses

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

| Out-of-Pocket Maximum In-Network Example | | | |
|--|-----------------------------------|-------------------------------------|---|
| | Out-of-Pocket Expenses In-Network | Applied to Out-of-Pocket In-Network | Applied to Out-of-Pocket Out-of-Network |
| Retiree | \$2,500 | \$2,500 | \$0 |
| Spouse | \$2,500 | \$2,500 | \$0 |
| Total: | \$5,000 | \$5,000 | \$0 |

For the remainder of the calendar year, any additional covered medical expenses submitted by this family under the in-network option will be paid at 100% of *eligible expenses* (with some exceptions). If either the retiree or his/her spouse seeks in-network care, the out-of-network *out-of-pocket maximum* will not apply

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

| Out-of-Pocket Maximum Out-of-Network Example | | | |
|--|---------------------------------------|---|-------------------------------------|
| | Out-of-Pocket Expenses Out-of-Network | Applied to Out-of-Pocket Out-of-Network | Applied to Out-of-Pocket In-Network |
| Retiree | \$5,000 | \$5,000 | \$0 |
| Spouse | \$5,000 | \$5,000 | \$0 |
| Total: | \$10,000 | \$10,000 | \$0 |

For the remainder of the calendar year, any additional covered medical expenses submitted by this family under the out-of-network option will be paid at 100% of *eligible expenses* (with some exceptions). If either the retiree or his/her spouse seeks in-network care, the out-of-network *out-of-pocket maximum* will not apply.

Similar to a family deductible, a full family out-of-pocket maximum must be met even if only one family member is incurring expenses.

Example: A retiree has family coverage for himself and his spouse. The in-network out-of-pocket maximum is two times an individual limit of \$2,500, or \$5,000. During the calendar year, the retiree incurs in-network expenses of \$4,000, while his spouse incurs none:

| Out-of-Pocket Maximum In-Network Example | | | |
|--|-----------------------------------|----------------------------------|-------------------------------------|
| | Out-of-Pocket Expenses In-Network | Individual Plan Limit In-Network | Applied to Out-of-Pocket In-Network |
| Retiree | \$4,000 | \$2,500 | \$4,000 |
| Spouse | \$0 | \$2,500 | \$0 |
| Total: | \$5,000 | \$5,000 | \$4,000 |

Coinsurance will continue to apply until either the retiree or his spouse incurs an additional \$1000 in expenses.

Important

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

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

| Plan Features | Applies to the In-Network, Out-of-Pocket Maximum? | Applies to the Out-of-Network, Out-of-Pocket Maximum? |
|---|---|---|
| Payments toward the annual deductible | Yes | Yes |
| Member coinsurance payments | Yes | Yes |
| Charges for non-covered health services | No | No |
| Amount of any reduction in benefits you incur by not following prior notification or pre-certification requirements | No | No |
| Amounts you pay toward behavioral health services | Yes | No |
| Charges that exceed <i>eligible expenses</i> | Not applicable | No |
| Prescription drugs obtained through Medco | Yes | Yes |

Lifetime Maximums

The Plan does not have any lifetime maximums.

Section 5. Coverage/Limitations

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

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

Covered health services are health services and supplies that are:

- Provided for the purpose of preventing, diagnosing, or treating **sickness, injury**, mental illness, **substance abuse** or their symptoms
- Included in this section (subject to limitations and conditions and exclusions as stated in this **SPD**)
- Provided to a covered member who meets the Plan's eligibility requirements, as described in Section 1
- **Medically appropriate**

Note: If a health service is not listed in this Section as a covered health service, nor listed in the Exclusion Section as a specific exclusion in the Plan, it may or may not be a covered health service. Contact **UHC** Customer Service at 877-835-9855 for information.

Plan Highlights

The following tables highlight the coinsurance percentage amounts you will pay for various **covered health services**.

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

Important

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

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

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

Important

Some services require **prior notification**, notification or **pre-certification**, otherwise, you will receive reduced benefits or, in certain cases, no benefits. For a complete listing of these services, refer to Section 7, Accessing Care.

| Benefit | In-Network Option | Out-of-Network Option |
|---|---|--|
| Acupuncture Services | 20% | 30% |
| Allergy Services – office visit – testing – serum – allergy shot | 20% | 30% |
| Ambulance | Prior notification required for air and ambulance 20% | Prior notification required for air and ambulance 20% |
| Behavioral Health (Mental Health & Substance Abuse Program) | Pre-certification to UBH is required before receiving services for neuropsychological testing, intensive outpatient therapy programs, partial hospitalization programs, inpatient stays, and residential treatment facilities as follows: (see page 5-8) 20% | Pre-certification to UBH is required before receiving services for neuropsychological testing, intensive outpatient therapy programs, partial hospitalization programs, inpatient stays, and residential treatment facilities as follows: (see page 5-8) 50%* |

Important

For detailed benefit provisions, including any limits that may apply, please refer to the information following this table. Refer to Section 6 for exclusions.

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

| Benefit | In-Network Option | Out-of-Network Option |
|--|---|---|
| Biofeedback Services | 20% | 30% |
| Chemotherapy – physician’s office – outpatient facility – inpatient facility | 20% | 30% |
| Chiropractic Services | 20% | 30% |
| Dental Services – physician’s office – outpatient facility – inpatient facility | Prior Notification Required for accidental dental services. 20% | Prior Notification Required for accidental dental services. 30% |
| Diagnostic Tests – physician’s office – outpatient facility – inpatient facility | 20% | 30% |
| Durable Medical Equipment | Prior Notification Required if \$1,000 or more 20% | Prior Notification Required if \$1,000 or more 30% |
| Emergency Room Care | 20% | True Emergency 20% Non Emergency 30% |
| Eye Exam for Non-refractive Care due to Sickness or Injury to the Eye | 20% | 30% |
| Eyeglasses/ Contact Lenses | 20% | 30% |
| Family Planning – physician’s office – outpatient facility – inpatient facility | 20% | 30% |
| Important <i>For detailed benefit provisions, including any limits that may apply, please refer to the information following this table. Refer to Section 6 for exclusions</i> | | |

| Benefit | In-Network Option | Out-of-Network Option |
|---|---|--|
| Hearing Aids/Exam – exam – hearing aid | 20% Note: Hearing exams for well-baby and well-child care as outlined under the preventive benefit will be covered at no cost to the member. | 30% |
| Home Health Care | Prior Notification Required 20% | Prior Notification Required 30% |
| Hospice Services | Prior Notification Required 20% | Prior Notification Required 30% |
| Injections in Physician's Office – allergy shots – immunizations/ vaccines – all other injections | 20% | 30% |
| Inpatient Services | Prior Notification Required 20% | Prior Notification Required 30% |
| Lab – inpatient – outpatient – physician's office | 20% | 30% |
| Maternity | Notification may be required (refer to page 5-15) | Notification may be required (refer to page 5-15) |
| – initial visit to determine pregnancy status – delivery, prenatal, and postnatal care – nursery care for well-baby newborn | 20% | 30% |
| Medical Supplies | 20% | 30% |
| Nutritional Counseling | 20% | 30% |
| Office Care – PCP – specialist | 20% | 30% |

Important

For detailed benefit provisions, including any limits that may apply, please refer to the information following this table. Refer to Section 6 for exclusions

| Benefit | In-Network Option | Out-of-Network Option |
|--|---|---|
| Organ Transplant | Prior Notification Required 20% | Prior Notification Required 30% |
| Outpatient Surgery – physician’s office – outpatient facility | 20% | 30% |
| Prescription drugs – physician’s office – retail pharmacy – mail order | 20% | 30% (mail order not available) |
| Preventive Care | No cost to you | 30% |
| Prosthetic Appliances | 20% | 30% |
| Radiation Therapy – physician’s office – outpatient facility – inpatient facility | 20% | 30% |
| Radiology – inpatient – outpatient – physician’s office | 20% | 30% |
| Rehabilitation Services (Outpatient) – physical therapy – occupational therapy – speech therapy – pulmonary rehabilitation – cardiac rehabilitation | 20% | 30% |
| Skilled Nursing Facility/Inpatient Rehabilitation Facility | Prior Notification Required 20% | Prior Notification Required 30% |
| Urgent Care Facilities | 20% | 30% |
| Important <i>For detailed benefit provisions, including any limits that may apply, refer to the information following this table. Refer to Section 6 for exclusions.</i> | | |

Additional Coverage Details

While the previous table (pages 5-2 through 5-5) provides information about the coverage levels you will pay, the following information provides detailed descriptions of cov-

ered health services. See Section 6, Exclusions, for information on what is excluded under this Plan.

Acupuncture Services

The Plan covers acupuncture services as follows:

- X-rays and other services provided by a licensed acupuncturist or Doctor of Oriental Medicine either in- or out-of-network with no review by ***UHC*** required
- A maximum benefit of 10 combined visits for acupuncture and chiropractic services per calendar year per covered member. This maximum applies to in- and out-of-network acupuncture and chiropractic benefits combined.

Allergy Services

The Plan covers services related to allergies as follows:

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

Ambulance Services

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

Ground Ambulance Services

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

Prior Notification to Care CoordinationSM is required for air ambulance service at least five business days before receiving services, or in an ***emergency***, within two business days after receiving services, or as soon as reasonably possible. If Care CoordinationSM is not notified, benefits will be reduced by \$300. See Section 7, Accessing Care, for more information.

Air Ambulance Services

- air ambulance is covered only when ground transportation is impossible or would put life or health in serious jeopardy

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

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

Behavioral Health Services

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

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

If services are not pre-certified, benefits will be reduced by \$300. Refer to Section 7, Accessing Care, for more information.

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

- evaluations and assessments
- diagnosis
- treatment planning
- referral services
- medication management
- individual and group therapeutic services
- intensive **outpatient** therapy programs
- crisis intervention
- psychological testing, including neuropsychological testing

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

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

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

- two partial-hospitalization days are counted as one 24-hour hospitalization day

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

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

Important

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

Guidelines

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

Biofeedback Services

The Plan covers biofeedback services as follows:

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

Cancer Services

UHC provides Plan members with access to designated United Resource Networks (**URN**) facilities through the Cancer Resource Services Program. It is not mandatory that you receive services through this Program, but if you do you may be eligible for additional benefits. Refer to Section 7, Accessing Care, for more information.

The Plan covers oncology services as follows:

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

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

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

Note: The services described under Travel and Lodging in Section 7, Accessing Care, are covered health services only in connection with cancer-related services received at a designated United Resource Networks facility through the Cancer Resource Services Program.

Chiropractic Services

The Plan covers chiropractic services as follows:

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

Dental Services

Prior notification to Care CoordinationSM is required at least five business days before follow-up (post-**emergency**) treatment begins. If Care CoordinationSM is not notified, benefits will be reduced by \$300. You do not have to provide notification before the initial **emergency** treatment. Refer to Section 7, Accessing Care, for more information.

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

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

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

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

Diagnostic Tests

The diagnostic tests the Plan covers include:

- laboratory and radiology
- computerized tomography (CT) scans
- position emission tomography (PET) scans
- magnetic resonance imaging (MRI)
- nuclear medicine
- echocardiograms
- electroencephalograms
- sleep studies

Durable Medical Equipment (DME)

Prior notification to Care CoordinationSM is required at least five business days before purchase or rental of ***DME*** for items with a purchase or cumulative rental value of \$1,000 or more. If Care CoordinationSM is not notified, benefits will be reduced by \$300. Refer to Section 7, Accessing Care, for more information.

The Plan covers ***durable medical equipment*** as follows:

- ordered or provided by a ***physician*** for ***outpatient*** use
- used for medical purposes
- not consumable or disposable
- not of use to a person in the absence of a ***sickness, injury***, or disability
- durable enough to withstand repeated use
- appropriate for use in the home

Important

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

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

- wheelchairs
- hospital beds
- equipment for the treatment of chronic or acute respiratory failure or conditions
- equipment to administer oxygen
- oxygen

- orthopedic shoes
 - up to two pairs of custom-made orthopedic shoes are covered per year when necessary due to illness such as diabetes, post polio, or other such conditions
- mastectomy bras
 - up to two per calendar year will be allowed following a mastectomy
- C-PAP machine
- bilirubin lights

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

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

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

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

Emergency Care

Important

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

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

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

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

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

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

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

Eye Exam/Eyeglasses/Contact Lenses

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

Family Planning

The Plan covers family planning services as follows:

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

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

Hearing Aids/Exam

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

Home Health Care Services

Prior notification to Care CoordinationSM is required at least five business days before receiving services. If Care CoordinationSM is not notified, benefits will be reduced by \$300. Refer to Section 7, Accessing Care, for more information.

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

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

Hospice Services

Prior notification to Care CoordinationSM is required at least five business days before receiving services. If Care CoordinationSM is not notified, benefits will be reduced by \$300. Refer to Section 7, Accessing Care, for more information.

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

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

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

Injections in Physician's Office

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

- In-network
 - allergies – 20% of **eligible expenses** after the **deductible**
 - Immunizations/vaccines – no cost to you as outlined under the Preventive Care benefit in this Section
 - All other injections (e.g., cortisone, depo-provera, etc.) – 20% of **eligible expenses** after **deductible**
- For out-of-network services, you pay 30% of **eligible expenses**, after the **deductible**

Inpatient Services

Prior notification to Care CoordinationSM is required as follows:

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

If Care CoordinationSM is not notified, benefits will be reduced by \$300. Refer to Section 7, Accessing Care, for more information.

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

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

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

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

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

Maternity Services

Newborn and Mother's Health Protection Act: Under federal law, mothers and their newborns who are covered under group health plans are guaranteed a stay in the **hospital** of not less than 48 hours following a normal delivery or not less than 96 hours following a cesarean section. Notification to Care CoordinationSM is **ONLY** required if your stay will be longer than 48 hours following a normal delivery or longer than 96 hours following a cesarean section. If Care CoordinationSM is not notified within two business days or as soon as reasonably possible, benefits will be reduced by \$300. Refer to Section 7, Accessing Care, for more information.

The Plan pays for maternity services as follows:

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

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

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

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

Benefits for birthing services rendered in the home will be paid according to the network status of the *physician* with whom the licensed nurse midwife is affiliated. If the licensed nurse midwife is not affiliated with a *physician* and is not a part of the network, reimbursement will be paid on an out-of-network level. If you are admitted to the *hospital*, you must notify Care CoordinationSM within two business days or as soon as reasonably possible. Refer to Section 7, Accessing Care, for more information.

Important

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

Medical Supplies

The Plan covers certain medical supplies to include:

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

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

Nutritional Counseling

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

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

Obesity Surgery

Prior notification to Care CoordinationSM is required at least five business days before receiving services. If Care CoordinationSM is not notified, benefits will be reduced by \$300. Refer to Section 7, Accessing Care, for more information.

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

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

Office Visits

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

- Consultations
- Second opinions
- Post-operative follow-up
- Services after hours and **emergency** office visits (allowed separately)
- Allergy testing
- Office surgery
- Supplies dispensed by the provider
- Diagnostic tests
- Laboratory services
- Radiology services
- Chemotherapy
- Radiation therapy

Organ Transplants

UHC provides Plan members with access to designated **URN** facilities through the Transplant Resource Services Program. It is not mandatory that you receive services through this Program, but if you do you may be eligible for additional benefits. **Prior notification** to Care CoordinationSM or the Transplant Resource Services Program is required as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed). If the Transplant Resource Services Program or Care CoordinationSM is not notified, benefits will be reduced by \$300. Refer to Section 7, Accessing Care, for more information.

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

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

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

Outpatient Surgical Services

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

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

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

Prescription Drugs

The items below are covered under UHC:

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

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

Preventive Care

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

Important

*It is solely up to the provider as to whether the service is coded as preventive or diagnostic. Neither Sandia nor **UHC** can direct the pro-*

vider to bill a service in any particular way. The issue as to how it is billed is between you and your provider.

Routine/Annual Physical Exams

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

Note: In the case of well-woman exams, the Plan will reimburse one well-woman exam per calendar year in addition to a routine physical/annual exam.

Well-Baby Care (0-2 years)

| Routine Physical Exam (including height & weight) | Hearing Exam | Thyroid Screen | Serum Lead Screen | PKU Screen | Sickle Cell Anemia Screen | Hemoglobin/Hematocrit |
|---|--------------|----------------|-------------------|------------|---------------------------|-----------------------|
| Birth, 1, 2, 4, 6, 9, 12, 18, and 24 months | As needed | As needed | As needed | As needed | As needed | Between 9-12 months |

Well-Child Care (3-10 years)

| Routine Physical Exam (including height and weight) | Hearing Exam |
|---|--------------|
| Annually | As needed |

Well-Adolescent Care (11-18 years)

| Routine Physical Exam (including height, weight, & blood pressure) | Chlamydia Screen | Rubella Screen | Sexually Transmitted Diseases Screen |
|--|---------------------|-----------------------------|--------------------------------------|
| Annually | Annually, as needed | Limited to one per lifetime | As needed |

Well-Adult Care (19 years and older)

| Routine Physical Exam (including height, weight, & blood pressure) | Chlamydia Screen | Rubella Screen | Sexually Transmitted Diseases Screen |
|--|---------------------|-----------------------------|--------------------------------------|
| Annually | Annually, as needed | Limited to one per lifetime | As needed |

Immunizations/Flu Shot Services

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

Laboratory Services

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

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

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

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

Cancer Screening Services

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

| Service | Allowed Frequency | Allowable Age |
|-------------------------|--------------------------|-------------------------------------|
| Pap test | Annual | Upon turning 14 |
| Prostrate Antigen test | Annual | Upon turning 50 |
| Mammogram* | Baseline, Annual | Between ages 35-39, upon turning 40 |
| Fecal occult blood test | Annual | Upon turning 50 |
| Sigmoidoscopy** | Once every five years | Upon turning 50 |
| Colonoscopy** | Once every 10 years | Upon turning 50 |
| Barium enema** | Once every five years | Upon turning 50 |

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

** You are entitled to the following:

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

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

Pregnancy-Related Preventive Care Services

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

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

Bone Density Testing

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

Prosthetic Devices/Appliances

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

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

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

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

Professional Fees for Surgical and Medical Procedures

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

The Plan will pay the following surgical expenses:

- Only one charge is allowed for the operating room and for anesthesia.
- A surgeon will not be paid as both a co-surgeon and an assistant surgeon.
- Expenses for certified first assistants are allowed.
- Incidental procedures are those services carried out at the same time as a more complex, primary procedure. The incidental procedure may be a part of the primary procedure and require little or very little additional time and resources; therefore, they are usually not covered.
- A surgical procedure that is performed and not considered incidental to the primary procedure will be reimbursed at half of the allowable. For example:

- When bilateral surgical procedures are performed by one or two surgeons, the Plan will consider the first procedure at the full allowed amount, and the second procedure will be considered at half of the allowed amount of the listed surgical unit value.
- Foot surgery – for a single surgical field/incision or two surgical fields/incisions on the same foot, the Plan will allow the full amount for the procedure commanding the greatest value; half of the full amount for the second procedure; half of the full amount for the third procedure; and a quarter of the full amount for each subsequent procedure. Also, if procedure 11721 is billed in conjunction with 10056 and 10057, these will be allowed to be reimbursed separately without bundling when billed with a medical diagnosis.

Reconstructive Procedures

Prior notification to Care CoordinationSM is required at least five business days before undergoing a ***reconstructive procedure***. If Care CoordinationSM is not notified, benefits are reduced by \$300. Refer to Section 7, Accessing Care, for more information.

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

Important

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

Improving or restoring physiology function means that the organ or body part is made to work better. An example of a ***reconstructive procedure*** is surgery on the inside of the nose so that a person's breathing can be improved or restored. There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Upper eyelid surgery, for example, is sometimes performed to improve vision, which is considered a ***reconstructive procedure***. But in other cases, improvement in appearance is the primary intended purpose, which is considered a ***cosmetic procedure***. ***Cosmetic procedures*** are not covered under this Plan. Refer to Section 6, Exclusions, for more information.

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

Rehabilitation Services

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

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

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

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

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

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Prior notification to Care CoordinationSM is required as follows:

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

If Care CoordinationSM is not notified, benefits will be reduced by \$300. Refer to Section 7, Accessing Care, for more information.

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

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

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

Benefits are available when skilled nursing and/or inpatient rehabilitation facility services are needed on a daily basis. Benefits are also available in a ***skilled nursing facility*** or in-

patient rehabilitation facility for treatment of a *sickness* or *injury* that would have otherwise required an *inpatient stay* in a *hospital*.

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

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

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

Temporomandibular Joint (TMJ) Syndrome

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

Urgent Care

The Plan will cover *urgent care* as follows:

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

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

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

Section 6. Exclusions

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

General Plan Exclusions

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

| Exclusions | Examples |
|--|--|
| Administrative fees, penalties, and limits | <p>Charges that exceed what the claims administrator determines are eligible expenses</p> <p>Insurance filing fees, attorney fees, physician charges for information released to claims administrator, and other service charges and finance or interest charges</p> <p>Amount you pay as a result of failure to contact UHC for prior notification or pre-certification, including unauthorized care</p> <p>Charges incurred for services rendered that are not within the scope of a provider's licensure</p> <p>Charges for missed appointments</p> |
| Behavioral Health Services | <p>Conduct disturbances unless related to a coexisting condition or diagnosis otherwise covered</p> <p>Educational, vocational, and/or recreational services as outpatient procedures</p> <p>Biofeedback for treatment of diagnosed medical conditions (see medical benefit for biofeedback)</p> <p>Treatment for learning disabilities and pervasive developmental disorders (including autism) other than diagnostic evaluation</p> <p>Treatment for insomnia, other sleep disorders, dementia, neurological disorders, and other disorders with a known physical basis (certain treatments may be covered under medical portion of the Plan)</p> <p>Treatment that is determined by UBH to be for the member's personal growth or enrichment</p> <p>Court-ordered placements when such orders are inconsistent with the recommendations for treatment of a UBH participating provider for mental health or UBH</p> <p>Services to treat conditions that are identified by the most current edition of the <i>Diagnostic and Statistical Manual of Mental Disorders</i> as not being attributable to a mental disorder</p> <p>Sex transformations</p> <p>Any services or supplies that are not medically appropriate</p> <p>Custodial care</p> |

| Exclusions | Examples |
|------------|--|
| | <p>Pastoral counseling</p> <p>Developmental care</p> <p>Treatment for caffeine or tobacco addictions (with the exception of hypnotherapy and biofeedback for tobacco addiction), withdrawal, or dependence</p> <p>Aversion therapies</p> <p>Treatment for codependency</p> <p>Non-abstinence-based or nutritionally-based treatment for substance abuse</p> <p>Services, supplies, or treatments that are covered for benefits under the medical part of this Plan</p> <p>Treatment or consultations provided via telephone, except if used for transition of care or interim care for a maximum of six months</p> <p>Services, treatments, or supplies provided as a result of a Worker's Compensation law or similar legislation, or obtained through, or required by, any government agency or program, whether federal, state, or any subdivision, or caused by the conduct or omission of a third party for which the member has a claim for damages or relief, unless the member provides UBH with a lien against the claim for damages or relief in a form and manner satisfactory to UBH</p> <p>Non-organic erectile dysfunction (psychosexual dysfunction)</p> <p>Treatment for conduct and impulse control disorders, personality disorders, paraphilias (unusual sexual urges), and other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by UBH</p> <p>Services or supplies that</p> <ul style="list-style-type: none"> ○ are considered experimental or investigational drugs, devices, treatments, or procedures ○ result from or relate to the application of such experimental or investigational drugs, devices, treatments, or procedures <p>Wilderness programs, boot-camp-type programs, work-camp-type programs, or recreational type programs</p> <p>Services or supplies that are primarily for the covered member's education, training, or development of skills needed to cope with an injury or sickness</p> <p>Substance abuse benefits for Class II dependents</p> |

| Exclusions | Examples |
|-----------------------------|--|
| Congenital Heart Disease | <p>CHD services other than as listed below are excluded from coverage unless determined by United Resource Networks or Care CoordinationSM to be proven procedures for the involved diagnoses:</p> <ul style="list-style-type: none"> ○ Outpatient diagnostic testing ○ Evaluation ○ Surgical interventions ○ Interventional cardiac catheterizations (insertion of a tubular device in the heart) ○ Fetal echocardiograms (examination, measurement, and diagnosis of the heart using ultrasound technology and ○ Approved fetal interventions |
| Dental Procedures | <p>Dental procedures are not covered under this Plan except when the services are medical in nature for injuries to sound, natural teeth, the jawbone, or surrounding tissue, or birth defects. Treatment must be initiated within 12 months of injury.</p> <p>Dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not covered.</p> |
| Drugs | <p>Outpatient prescription drugs, including drugs obtained that are self-administered, are covered under the Prescription Drug Program (see Appendix A), except drugs dispensed, administered, and billed through the provider or facility that is approved by UHC for coverage, and all intravenously administered medications.</p> |
| Employee Assistance Program | <p>EAP benefits are not available to retirees, survivors, and long-term disability terminatees or their covered dependents</p> |
| Equipment | <p>Exercise equipment (e.g., exercycles, weights, etc.)</p> <p>Hearing aids for hearing loss (see benefit under hearing aids for sickness and injury coverage)</p> <p>Braces prescribed to prevent injuries while you are participating in athletic activities</p> <p>Household items, including but not limited to</p> <ul style="list-style-type: none"> ○ air cleaners and/or humidifiers ○ bathing apparatus ○ scales or calorie counters ○ blood pressure kits ○ water beds <p>Personal items, including but not limited to</p> <ul style="list-style-type: none"> ○ support hose, except medically appropriate surgical or compression stockings ○ foam cushions ○ pajamas <p>Items payable under the Prescription Drug Program (see Appendix A)</p> <p>Equipment rental fees above the purchase price, with the exception of oxygen equipment</p> |

| Exclusions | Examples |
|---|---|
| Experimental or investigative treatment | Experimental or investigative drugs, devices, medical treatments or procedures, and any related services |
| Hospital fees | <p>Expenses incurred in any federal hospital, unless the covered member is legally obligated to pay</p> <p>Hospital room and board charges in excess of the semi-private room rate unless medically appropriate and approved by UHC/UBH</p> <p>In-hospital personal charges (e.g., telephone, barber, TV service, toothbrushes, slippers)</p> |
| Hypnotherapy | Hypnotherapy is generally not a covered health service, but the Plan will allow up to five visits per lifetime for smoking cessation |

| | |
|--|---|
| Infertility, Reproductive, and Family Planning | <p>Infertility or reproduction benefits including, but not limited to:</p> <ul style="list-style-type: none"> ○ in vitro fertilization (IVF) ○ gamete intrafallopian transfer (GIFT) ○ zygote intrafallopian transfer (ZIFT) ○ artificial insemination ○ embryo transport ○ donor ovum and semen and related costs including collection, preparation and storage of <p>Purchase of eggs</p> <p>Services related to or provided to anonymous donors</p> <p>Services provided by a doula (labor aide)</p> <p>Donor expenses related to donating eggs/sperm (including prescription drugs); however, charges to extract the eggs from a covered employee for a donor are allowed</p> <p>Expenses incurred by surrogate mothers</p> <p>Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes</p> <p>Over-the-counter medications for birth control/prevention</p> <p>Parenting, pre-natal, or birthing classes</p> |
| Miscellaneous | Eye exams except as outlined under Section 5, Coverage/Limitations |
| | <p>Eyeglasses or contact lenses prescribed, except as outlined under Section 5, Coverage/Limitations. Contact lenses are not considered a prosthetic device.</p> <p>Modifications to vehicles and houses for wheelchair access</p> <p>Health club memberships and programs or spa treatments</p> <p>Treatment or services</p> <ul style="list-style-type: none"> ○ incurred when the patient was not covered under this Plan even if the medical condition being treated began before the date your coverage under the Plan ends ○ for sickness or injury resulting from the covered member's intentional acts of aggression, including armed aggression, except for injuries inflicted on an innocent bystander (e.g., you did not start the act of ag- |

| Exclusions | Examples |
|------------|--|
| | <p>gression)</p> <ul style="list-style-type: none"> ○ for job-incurred injury or illness for which payments are payable under any Workers' Compensation Act, Occupational Disease Law, or similar law ○ while on active military duty ○ that are reimbursable through any public program other than Medicare or through no-fault automobile insurance <p>Charges in connection with surgical procedures for sex changes</p> <p>Charges for blood or blood plasma that is replaced by or for the patient</p> <p>Conditions resulting from insurrection, except for injuries inflicted on an innocent bystander who is a covered member under this Plan</p> <p>Christian Science practitioners and facilities</p> <p>Food of any kind unless it is the only source of nutrition, there is a diagnosis of dysphagia (difficulty swallowing) or in cases of PKU or RH factor.</p> <p>Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk</p> <p>Foods to control weight, treat obesity (including liquid diets), lower cholesterol, or control diabetes</p> <p>Oral vitamins and minerals (with the exception of oral calcium supplements for clinically documented hypoparathyroidism and Niferex and certain prescription vitamins) as outlined in Appendix A, Prescription Drug Program</p> <p>Herbs and over-the-counter medications except as specifically allowed under the Plan</p> <p>Charges prohibited by federal anti-kickback or self-referral statutes</p> <p>Chelation therapy, except to treat heavy metal poisoning</p> <p>Diagnostic tests that are:</p> <ul style="list-style-type: none"> ○ Delivered in other than a physician's office or health care facility ○ Self-administered home-diagnostic tests, including but not limited to HIV and pregnancy tests <p>Domiciliary care</p> <p>Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for ten seconds or longer). Appliances for snoring are always excluded.</p> <p>Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments when:</p> <ul style="list-style-type: none"> • Required solely for purposes of career, education, camp, employment, insurance, marriage or adoption; or as a result of incarceration • Conducted for purposes of medical research • Related to judicial or administrative proceedings or orders or • Required to obtain or maintain a license of any type <p>Private duty nursing received on an inpatient basis</p> <p>Respite care</p> |

| Exclusions | Examples |
|--|---|
| | Rest cures Storage of blood, umbilical cord, or other material for use in a covered health service, except if needed for an imminent surgery |
| Not a covered health service and/ or not medically appropriate | Treatments or services determined not to be medically appropriate and not to be a covered health service by UHC or UBH (see medically appropriate in Appendix C, UHC HDHP Acronyms/Definitions) |
| Old claims | Claims received 12 months after the date charges were incurred |
| Physical Appearance | Breast reduction/augmentation except after breast cancer and/or if medically appropriate Any loss, expense, or charge that results from cosmetic or reconstructive surgery, except after breast cancer. Exceptions to this exclusion include: <ul style="list-style-type: none"> • repair of defects that result from surgery for which the member was paid benefits under the policy • reconstructive (not cosmetic) repair of a congenital defect that materially corrects a bodily malfunction. Note: For the purposes of this exclusion, poor self-image or emotional or psychological distress does not constitute a bodily malfunction. Liposuction Pharmacological regimens Nutritional procedures or treatments Tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery, and other such skin abrasion procedures) Replacement of an existing intact breast implant unless there is documented evidence of silicon leakage Physical conditioning programs, such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity Wigs regardless of the reason for hair loss Treatments for hair loss |
| Providers | Services: <ul style="list-style-type: none"> • Performed by a provider who is a family member by birth or marriage, including your spouse, brother, sister, parent, or child • A provider may perform on himself or herself • Performed by a provider with your same legal residence • Provided at a diagnostic facility (hospital or otherwise) without a written order from a provider • Ordered by a provider affiliated with a diagnostic facility (hospital or otherwise) when that provider is not actively involved in your medical care |

| Exclusions | Examples |
|---|--|
| | <ul style="list-style-type: none"> ○ Prior to ordering the service or ○ After the service is received <p>This exclusion does not apply to mammography testing.</p> |
| Services, supplies, therapy, or treatments | <p>Charges that are:</p> <ul style="list-style-type: none"> • custodial in nature • otherwise free of charge to the member • furnished under an alternative medical plan provided by Sandia • for aromatherapy or rolfing (holistic tissue massage) • for developmental care after a maintenance level of care has been reached • for maintenance care • for massage therapy unless performed by a licensed chiropractor, physical therapist, or physician as a manual therapy technique for lymphatic drainage • for educational therapy when not medically appropriate • for educational testing • for smoking-cessation programs, except for biofeedback and hypnotherapy, which are limited to a maximum of five visits each per lifetime • for surgery and other related treatment that is intended to correct near-sightedness, farsightedness, presbyopia, and astigmatism, including but not limited to procedures such as laser and other refractive eye surgery and radial keratotomy |
| Surgical and non-surgical treatment for obesity | <p>Surgical operations for the correction of morbid obesity determined by UHC not to be medically appropriate to preserve the life or health of the member</p> <p>Treatment for over-the-counter appetite control, food addictions, or eating disorders that are not documented cases of bulimia or anorexia meeting standard diagnostic criteria as determined by UHC/UBH</p> |
| Transplants | <p>Organ and tissue transplants, including multiple transplants:</p> <ul style="list-style-type: none"> ○ Except as identified under Organ Transplants, Section 5, Coverage/Limitations ○ Determined by Care CoordinationSM not to be proven procedures for the involved diagnoses ○ Not consistent with the diagnosis of the condition <p>Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available)</p> <p>Donor costs for organ or tissue transplantation to another person unless the recipient is a covered member under this Plan</p> |
| Transportation | <p>Non-emergency ambulance services are not covered.</p> <p>Transportation, except ground ambulance and air ambulance services as outlined in Section 5, Coverage/Limitations</p> |

| Exclusions | Examples |
|------------|---|
| Travel | Travel or transportation expenses, even if ordered by a physician, except as identified under Travel and Lodging in Section 7, Accessing Care |

Section 7. Accessing Care

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

In-Network and Out-of-Network Options

The in-network option provides you access to *physicians*, facilities, and suppliers who are contracted with *UHC* and *UBH* to provide their services at negotiated fees. This results in lower out-of-pocket costs to you. When you use the in-network option of the *UHC* HDHP, all services and supplies covered must be acquired from in-network providers or suppliers and qualify as covered health services under this Plan (see Section 4, Deductibles and Maximums, and Section 5, Coverage/Limitations for coverage details). Some procedures may require *prior notification* or *pre-certification*, which you are responsible for asking your *physician* to obtain from *UHC* or *UBH* (refer to Prior Notification Requirements for Medical Services to Care CoordinationSM and Pre-Certification Requirements for Behavioral Health Services in this section). For the most updated in-network provider listings in your area, contact *UHC* Customer Service at 877-835-9855 or access the website at myuhc.com.

The advantages of using the in-network option include:

- Lower coinsurance
- Lower deductibles (for employees)
- Lower out-of-pocket maximums
- No responsibility for amounts exceeding eligible expenses
- Generally, no claims to file

The out-of-network option offers a lower level of benefit but enables the member to get services from licensed providers outside the Plan network. No referrals are required. The member is responsible for *deductibles*, *coinsurance*, and amounts exceeding *eligible expenses*. The member is also responsible for filing all claims not filed by the provider and must obtain prior authorization/*pre-certification* for all *hospital* care and certain medical and *behavioral health* care in order to be eligible for full benefits. Refer to Section 4, Deductibles and Maximums, and Section 5, Coverage/Limitations.

Important

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

Prior Notification Requirements for Medical Services to Care CoordinationSM

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

Important

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

You or your provider must notify Care CoordinationSM for:

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

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

Important

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

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

- Congenital heart disease services
- Dental services stemming from an accident or *sickness* or *injury*
- **Durable medical equipment** for items with a purchase or cumulative rental value of \$1,000 or more
- Home health care
- Hospice care

- Hospital inpatient stay, including emergency admission
- Maternity care that exceeds the delivery timeframes as described in Section 5, Coverage/Limitations

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

- Reconstructive procedures
- Skilled nursing facility/inpatient rehabilitation facility services
- Transplantation services

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

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

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

Pre-Certification Requirements for Behavioral Health Services

To find out about *pre-certification* requirements for *behavioral health*, see Behavioral Health Program in this section.

Important

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

Predetermination of Benefits

The *UHC* HDHP covers a wide range of medical care treatments and procedures. However, medical treatments that are *investigational*, *experimental*, or *unproven* to be medically effective are not covered by the Plan. Contact *UHC* or *UBH* before incurring charges that may not be covered.

In addition, some services may be covered only under certain circumstances and/or may be limited in scope, including but not limited to speech therapy, occupational therapy, temporomandibular joint (*TMJ*) syndrome, procedures that may have a cosmetic effect, and physical therapy. Predetermination of benefits is recommended to help you determine your out-of-pocket expense. Also, some benefits require *prior notification* or *pre-certification*; therefore, it is important that you call *UHC* or *UBH* for information on

covered services. If you have any questions about how to obtain a predetermination of benefits, contact **UHC** customer service at 1-877-835-9855.

Non-emergency or Non-urgent Care Away from Home

UHC and **UBH** have contracted with providers in more than 370 metropolitan areas. If you are not experiencing an **emergency** or urgent situation, call **UHC** or **UBH** to obtain information on in-network providers in the area. If there are no in-network providers within a 30-mile radius of your location, contact **UHC** Customer Service for assistance.

Behavioral Health Program

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

Important

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

You or your provider must pre-certify with **UBH** for:

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

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

Pre-certification is required for the following **behavioral health** services from in- or out-of-network providers.

- Neuropsychological testing
- Intensive outpatient stays/programs
- Inpatient hospitalization

- Partial hospitalization
- Residential treatment stays/programs

Important

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

The following chart summarizes the benefits and limitations.

| UBH - Behavioral Health Program | |
|---|--|
| In-Network Option | Out-of-Network Option |
| Pre-certification required from UBH for inpatient, residential, partial hospitalization, neuropsychological testing or intensive out-patient stays/programs | Pre-certification from UBH for inpatient residential, partial hospitalization, neuropsychological testing or intensive outpatient stays/programs |
| Out-of-pocket maximum applicable | Out-of-pocket maximum not applicable |
| Must use UBH network provider or facility | Use of non-UBH network provider or facility |
| Plan pays 80% of eligible expenses after deductible for inpatient and outpatient services | Plan pays 50% of eligible expenses (after deductible) for inpatient and outpatient services |
| Annual visit maximum – 20 visits in-network and out-of-network combined per calendar year | Annual visit maximum – 20 visits in-network and out-of-network combined per calendar year |
| 60 days inpatient combined in- and out-of-network for mental health and substance abuse per calendar year | 60 days inpatient combined in- and out-of-network for mental health and substance abuse per calendar year |

In-Network Option

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

Out-of-Network Option

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

If a member is admitted to a **hospital** on an **emergency** basis that is not in the network and services are covered, in-network benefits will be paid until the patient is stabilized.

Once stabilized, the patient must be moved to a network *hospital* to continue in-network benefits. The patient may elect to remain in the out-of-network *hospital* and receive out-of-network benefits, as long as *UBH* confirms the treatment to be *medically appropriate*.

Provider Networks

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

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

In the Greater Albuquerque area, the providers, specialty care *physicians*, *hospitals*, and other health care providers/facilities participating in the *UHC* network are affiliated with Presbyterian and University of New Mexico *hospitals*. In some cases, *UHC* has established direct contracts with other providers. The *participating providers* work with *UHC* and *UBH* to organize an effective and efficient health care delivery system. Outside the greater Albuquerque area, *UHC* and *UBH* have contracted with providers offering in-network care.

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

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

Note: If your provider is interested in becoming an in-network provider, the provider can call *UHC* customer service to inquire about the process. There is also a provider nomination form located on the myuhc.com website with user ID and password of SNL.

United Resource Networks (URN) Programs

UHC offers designated *URN* programs for congestive heart disease, reproductive services, cancer services, and organ transplants for members in the *UHC* High Deductible Health Plan. Individuals with complex, unusual, or rare medical conditions have a likelihood of better outcomes when they are diagnosed and treated by medical professionals with precise clinical expertise. The *URN* programs were developed to support safe, successful, and *cost-effective* support of individuals with these conditions. These programs are optional and are not required in order to receive benefits. However, your costs may be

lower due to the fact that these networks typically have better negotiated rates with **UHC**. In addition, you may have access to additional facilities on an in-network basis through these programs. Finally, for transplants, cancer and congenital heart disease services, you may be eligible for a travel and lodging benefit through these programs as described on the following page. To access information on these programs, call 1-877-835-9855.

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

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

Important

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

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

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

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

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

A combined overall maximum benefit of \$10,000 per covered patient applies for all travel, lodging, and meal expenses reimbursed under this Plan in connection with all can-

cer treatments and transplant procedures and CHD treatments during the entire period that person is covered under this Plan.

Transplant Resource Services Program (Organ and Tissue Transplantation)

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

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

Transplant Resource Services contracts for the following organ and blood/marrow transplant services:

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

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless determined by Care CoordinationSM to be a proven procedure for the involved diagnoses.

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

- Pre-transplant evaluation
- *Hospital* and *physician* fees
- Organ acquisition and procurement, blood/marrow acquisition and donor search charges
- Transplant procedure
- Up to 12 months of follow-up care for transplant-related services
- The Transplant Access Program – for geographic access, economic value and administrative relief. The Transplant Access Program provides discounted rates for transplantation at a number of medical centers throughout the United States

that are not in the Transplant Resources Premium Network. Participating Transplant Access Program *physicians* and other health care professionals do not undergo Transplant Resource Services' rigorous credentialing process; therefore, clinical information regarding these providers is not available to promote referral.

- Extra Contractual Services – for contracting expertise on a case-by-case basis. These services are available on a case-by-case basis for patient referrals that fall outside of The Transplant Resource Services Premium Network or The Transplant Access Program.

For information on transplant coverage, refer to Section 5, Coverage/Limitations.

Cancer Resource Services Program

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

- Consultation from nurses about options to help you make an informed decision about which cancer care provider is best for you
- In-network coverage for care at cancer centers that have passed rigorous criteria
- Access to information about coverage, scheduling appointments, finding lodging, and other services
- Accurate diagnosis and few complications
- Care that is planned, coordinated, and provided by a team of experts who specialize in the patient's specific cancer
- Appropriate therapy
- Higher survival rates, shorter length of stay and decreased costs

For information on coverage, refer to Section 5, Coverage/Limitations.

Congenital Heart Disease Resource Services Program

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

Goals of CHD Resource Services include:

- Provide access to quality care for individuals with CHD
- Provide information regarding "best practice" in CHD care
- Build awareness among treating *physicians* and parents regarding the availability of CHD Resource Services Program
- Promote identification of individuals with CHD in-utero or at birth. This allows time for education and guidance offering the opportunity for improved outcomes and decreased CHD days, resulting in lower-cost CHD events.

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

Shared Savings Program

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

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

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

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

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

Provider Directories

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

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

Provider Searches Online

To search for a provider online, go to www.myuhc.com. It is easy and only takes a few minutes. All that is needed is access to the Internet:

- Log on to www.myuhc.com (you will need to register)
- To find medical providers, select Physicians & Facilities

- To find a physician, select Find a Physician
- To find a hospital, select Find a Hospital
- To find **behavioral health** providers, select Physicians & Facilities
 - Select Find Mental health/Substance Abuse Care
 - Click on Go To LiveAndWorkWell

When You Schedule An Appointment

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

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

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

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

When You Change Your Address

Retirees need to contact the Retirement Coordinator through Sandia **HBES**. **COBRA** and surviving spouse participants should notify the **COBRA** coordinator at (505) 844-0358.

If you relocate, your **PPO** network could change. For provider information, access myuhc.com for the most updated provider information.

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

NM **HBES**: (505) 844-4237 or 1-800-417-2634, then 844-4237 (**HBES**)
 CA Benefits: (925) 294-2254

UHC Customer Service

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

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

Identification Cards

If you have elected single coverage, you will receive one **UHC HDHP ID** card. If you have elected family coverage, you will receive two **ID** cards.

Important

*If you have elected family coverage and one of your covered dependents is **Medicare primary**, you will receive separate **ID** cards. You will receive an **ID** card with your name and your non-**Medicare-primary** covered dependents listed on the **ID** card. The unique subscriber number on your **ID** card is linked to **your** Social Security number. Your **Medicare primary** covered dependent (who is covered under the **UHC Senior Premier PPO Plan**) will receive a separate **ID** card with his/her own unique subscriber number linked to his/her Social Security number. You and your non-**Medicare-primary** covered dependents need to use your **ID** card and your unique subscriber number, while your **Medicare primary** covered dependent needs to use his/her **ID** card and unique subscriber number. If you don't use the right **ID** card, your claims may be denied.*

You may obtain additional **ID** cards through myuhc.com or by calling **UHC** Customer Service at 1-877-835-9855. The **UHC HDHP ID** card identifies you to providers as an eligible Plan member. This card contains:

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

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

Important

*Always present your **UHC HDHP** identification card when obtaining health care.*

Section 8. Resources for Healthy Living

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

Optum Nurse Line

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

Telephone

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

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

Important

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

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

Informational Recorded Messages

Nurse Line gives you another convenient way to access health information through informational recorded messages. Call 1-800-563-0416 to listen to one of the Health Information Library's over 1,100 recorded messages. There are also 590 messages available in Spanish.

Live Nurse Chat

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

UnitedHealth Focus Program

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

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

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

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

Case Management Program

If you are living with a chronic condition or dealing with complex health care needs, upon notification to Care CoordinationSM, **UHC** may assign to you a primary nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. Your primary nurse will provide you with a direct telephone number so you can contact them about your conditions, or your overall health and well-being.

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

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

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

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

Additional benefits of having a primary nurse include:

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

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

Disease Management Program

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

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

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

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

My UHC Website

UHC's member website, www.myuhc.com, provides information at your fingertips anywhere and anytime you have access to the Internet. Myuhc.com offers practical and personalized tools and information so you can get the most out of your benefits. Once you have registered at myuhc.com, you can:

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

If you have not already registered as a myuhc.com subscriber, go to myuhc.com and click on Register Now. Have your *UHC ID* card handy.

UnitedHealth Allies Health Discount Program

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

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

Products and services available under the program include:

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

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

To locate participating health care professionals:

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

Section 9. Claims and Appeals

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

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

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

Important

*If you are eligible for **Medicare primary** coverage and are covered under this Plan (under the continuation provisions under **COBRA** or as a result of end-stage renal disease), **Medicare** is your **primary** coverage and benefits are coordinated with **Medicare** as though you have both **Medicare** Parts A and B (whether you enrolled). If it is later determined that you became eligible for **Medicare primary** coverage and continued coverage under this Plan and Sandia paid benefits on a primary basis, the Plan will retroactively coordinate benefits with **Medicare**. If the Plan is unable to recover reimbursement from **Medicare** or the provider, you will be responsible for reimbursing the Plan. Refer to Appendix A, Prescription Drug Program, for information on prescription drug coverage under this Plan and **Medicare** Part D. Refer to the **Medicare** booklet *Medicare & You* for more information. Access the booklet from Medicare at www.medicare.gov or 1-800-633-4227, or by contacting your local Social Security office.*

Obtaining Reimbursement

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

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

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

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

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

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

Benefits Payments

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

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

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

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

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

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

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

Timing of Claims Payments

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

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

Urgent Care Claims

Time Frame for Response from UHC/UBH

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

Extension

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

Period for Claimant to Complete Claim

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

Other Related Notices

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

Non-urgent Pre-service Claims

Time Frame for Response from UHC/UBH

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

Extension

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

Period for Claimant to Complete Claim

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

Non-urgent Post-service Claims

Time Frame for Response from UBH/UHC

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

Extension

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

Period for Claimant to Complete Claim

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

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

Concurrent Care Claims

Time Frame for Response from UHC/UBH

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

Contents of Notice and Response from UHC and/or UBH

The notice will include all of the following:

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

Claim Denials and Appeals

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

If *UHC* and/or *UBH* denies your (or a dependent's) claim because of eligibility, refer to Section 1, Eligibility.

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

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

Filing an Appeal

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

Important

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

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

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

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

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

Send the written appeal to:

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

Two Levels of Appeals

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

Step 1: First Level of Appeal

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

Step 2: Second Level of Appeal

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

Timing of Appeals Decisions

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

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

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

Important

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

Urgent Care Claims

Period for Filing Appeals

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

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

Time Frame for Response from UHC/UBH

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

Non-urgent Pre-service Claims

Period for Filing Appeals

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

Time Frame for Response from UBH/UHC

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

Non-urgent Post-service Claims

Period for Filing Appeals

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

Time Frame for Response from UHC/UBH

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

External Review

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

Important

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

Recovery of Excess Payment

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

Important

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

Section 10. Coordination of Benefits

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

Policy

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

Important

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

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

Under the rules of the National Association of Insurance Commissioners (*NAIC*) for the *Coordination of Benefits (COB)*:

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

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

| | IF... | THEN... |
|----|--|--|
| 1 | the other plan (including HMOs) does not have a COB provision, | the plan with no COB provision is primary. |
| 2 | both plans have COB provisions, | the plan covering the person as an employee is primary and will pay benefits up to the limits of that plan. The plan covering the person as a dependent is secondary and pays the remaining costs to the extent of coverage. |
| 3 | both plans have COB provisions and use the birthday rule for dependent children coverage, | the plan covering the parent whose birthday comes first (month and day) in the year is the primary plan and will pay benefits first. The plan covering the other parent is secondary and pays the remaining costs to the extent of coverage. |
| 4 | both plans have COB but neither plan uses the birthday rule for dependent children's coverage, | the male-female rule applies. The rule says that the father's group insurance is the primary plan and will pay benefits first. The mother's group insurance is secondary and pays the remaining costs to the extent of her coverage. |
| 5 | both plans have COB but one parent is covered by the male-female rule and the other by the birthday rule, | the male-female rule applies. The rule says that the father's group insurance is the primary plan and will pay benefits first. The mother's group insurance is secondary and pays the remaining costs to the extent of her coverage. |
| 6 | a divorce or legal decree establishes financial responsibility for health care for the covered dependent children, | the parent who has the responsibility will be the holder of the primary plan. |
| 7 | a divorce decree does not establish financial responsibility for health care of the dependent, | the plan of the parent with custody is the primary plan. The other parent's plan is secondary. |
| 8 | a divorce decree does not establish financial responsibility and assigns joint custody, | each parent is primary when the child is living in that parent's home. |
| 9 | a divorce decree does not establish financial responsibility, and the parent with custody remarries, | the custodial parent's plan remains primary; the stepparent's plan is secondary; the non-custodial parent's plan is third. |
| 10 | payment responsibilities are still undetermined, | the plan that has covered the patient for the longest time is the primary plan. |

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid had it been the only plan involved

- The Plan pays the entire difference between the allowable expense and the amount paid by the primary plan – as long as this amount is not more than the Plan would have paid had it been the only plan involved

The maximum combined payment you may receive from all plans cannot exceed 100% of the total allowable expense.

Coordination of Benefits with Medicare

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

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

Important

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

Subrogation and Reimbursement Rights

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

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

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

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

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

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

Section 11. When Coverage Stops

This section outlines when coverage stops for retirees, Class I and Class II dependents, as well as causes for termination by the *claims administrator*. See Section 12, Continuation of Group Health Coverage, for specific rules governing when health coverage stops and how it may be continued for the above referenced groups.

Retirees

Plan benefits for retirees stop on the:

- 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 *Medicare primary* coverage. Contact Sandia *HBES* for more information.
- Submission of a fraudulent claim.

Important

*Health care coverage may be continued in some situations (refer to Section 12, Continuation of Group Health Coverage, for **COBRA** rules).*

Class I and Class II Dependents

Plan benefits for dependents stop on the:

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

Note: You must disenroll your dependents within 31 calendar days of the date your dependent becomes ineligible for coverage under this Plan. If you fail to do so, there may be severe consequences. Refer to Section 2, Enrollment & Disenrollment for more information.

Refer to Section 12, Continuation of Group Health Coverage, to determine whether your dependent may be eligible for temporary continued coverage under **COBRA**.

Termination for Cause

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

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

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

Certificate of Group Health Plan Coverage

Sandia complies with the requirements of the Health Insurance Portability and Accountability Act (**HIPAA**), Pub. L. 104–191, 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 (Code) to provide for, among other things, improved portability and continuity of health insurance coverage in the group and individual insurance markets, and group health plan coverage provided in connection with employment.

When the Sandia **HBES** learns of your loss of medical coverage, or the loss of coverage for your dependents, you will receive a Certificate of Group Health Plan Coverage. This certificate provides proof of your prior health care coverage for the past 18 months or less of coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have be-

fore you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the six-month period before your enrollment in the new plan. If you become covered under another group health plan, check with the *plan administrator* to see if you need to provide this certificate. You may also need this certificate to buy an insurance policy for yourself or your family that does not exclude coverage for medical conditions that are present before you enroll. You also have the right to request (for up to two years following the event that caused the loss of coverage) a Certificate of Group Health Plan Coverage by contacting Sandia's *HBES*.

Section 12. Continuation of Group Health Coverage

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

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

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

Retiree Medical Plan Option

If you retire from Sandia with a service pension or a disability pension, you are eligible for continued health coverage through Sandia under the Retiree Medical Plan option. You will be allowed to change your medical plan choice every year during the *open enrollment* period Sandia holds in the fall.

Upon retirement, if you are not eligible for *Medicare primary* coverage, the Retiree Medical Plan option allows you to enroll in either this Plan or the *UHC* Premier PPO Plan. Unless you elect the *UHC* High Deductible Health Plan within 31 calendar days of your retirement date, the *UHC* Premier PPO Plan will be your primary medical coverage until you reach age 65 or you become disabled and are eligible for *Medicare primary* coverage. Upon becoming eligible for *Medicare primary* coverage, you have the option of enrolling in either the *UHC* Senior Premier PPO Plan or the Presbyterian *Medicare PPO* Plan if you notify Sandia in writing within 31 calendar days of becoming eligible for *Medicare primary* coverage. If you do not notify the Sandia Benefits Department within 31 calendar days of becoming eligible for *Medicare primary* coverage, you will be defaulted to the *UHC* Senior Premier PPO Plan (unless as noted otherwise in the Important box on the following page).

Note: You can only enroll in the Presbyterian *Medicare PPO* Plan if you are enrolled in *Medicare* Parts A and B and do not have Class II dependents.

Important

Since all **Medicare primary** family members must be enrolled in the same plan and all **non-Medicare primary** family members must be enrolled in the same plan, upon becoming eligible for the **UHC High Deductible Health Plan**, the **UHC Senior Premier PPO Plan** or the **Presbyterian Medicare PPO Plan**, if one of the covered family members is already enrolled in one of these plans, you will only be able to enroll in the same plan as your covered family members. For example, if you are a **non-Medicare primary** retiree who is turning 65 and becoming eligible for **Medicare primary** coverage and you have a covered dependent that is already **Medicare primary** and is enrolled in the **Presbyterian Medicare PPO Plan**, you will be limited to enrolling in the **Presbyterian Medicare PPO Plan**.

Note: If you are a **dual Sandian** and your spouse remains an employee, you have the option of enrolling as a dependent under your spouse or if your spouse is already a retiree, you can change your election as to who is covered under whom.

Refer to Section 3, Group Health Plan Premiums, for information on the costs you will pay for coverage as a retiree.

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

Long-Term Disability Termined Medical Plan Option

If you terminate employment because of a disability and you are approved for and receiving long-term disability benefits through Sandia, you are eligible to continue health coverage through Sandia until the end of the month in which you recover and the Plan benefit ceases, the Plan benefit ceases for any other reason, or you die. You will be allowed to change your medical plan choice every year during the **open enrollment** period Sandia holds each fall.

If you are under age 65 and have been receiving Social Security disability benefits for 24 months or longer, or if you are age 65 or older, you are eligible for **Medicare primary** coverage. **Medicare** will become your primary coverage. Upon becoming eligible for **Medicare primary** coverage, you have the option of enrolling in either the **UHC Senior Premier PPO Plan** or the **Presbyterian Medicare PPO Plan** if you notify Sandia in writing within 31 calendar days of becoming eligible for **Medicare primary** coverage. If you do

not notify the Sandia Benefits Department within 31 calendar days of becoming eligible for **Medicare primary** coverage, you will be defaulted to the **UHC Senior Premier PPO Plan** (unless as noted otherwise in the Important box below). Note: You can only enroll in the Presbyterian **Medicare PPO Plan** if you are enrolled in **Medicare** Parts A and B and do not have Class II dependents.

Important

*Since all **Medicare primary** family members must be enrolled in the same plan and all non-**Medicare primary** family members must be enrolled in the same plan, upon becoming eligible for the **UHC High Deductible Health Plan**, the **UHC Senior Premier PPO Plan** or the Presbyterian **Medicare PPO Plan**, if one of the covered family members is already enrolled in one of these plans, you will only be able to enroll in the same plan as your covered family members.*

Refer to Section 3, Group Health Plan Premiums, for information on the costs you will pay as a disability terminnee.

As an alternative to electing coverage under the **Long-Term Disability Terminnee** option, the LTD **terminnee** may elect to temporarily continue the same health coverage as available to active employees by making an election under **COBRA**. Refer to **COBRA** in this Section for more information. If the LTD **terminnee** elects **COBRA** coverage instead of the LTD **Terminnee** option, the terminnee cannot elect the LTD option after **COBRA** coverage terminates. If the terminnee elects the LTD **Terminnee** option, he/she must waive rights to **COBRA**, as it is an either/or option.

Surviving Spouse Medical Plan Option

If you are a survivor or dependent of an on-roll regular employee or Sandia retiree who dies while covered under this Plan, you are eligible to continue health coverage through Sandia through the Surviving Spouse Medical Plan Option. You will be allowed to change your medical plan choice every year during the **open enrollment** period Sandia holds in the fall.

Sandia pays a portion of the full premium for continued health coverage for the first six months.

EXCEPTION

Sandia does NOT pay for the first six months of coverage for survivors of those retired employees paying their own premiums at the time of death.

The surviving spouse and dependents may continue health coverage for life if the election to continue is made within the first six months of death and by paying the applicable survivor rate for health coverage.

The surviving dependent *children* with no surviving parent may continue health coverage for an additional 30 months (beyond the initial first six months at the applicable employee or retiree premium-share amount) by paying the *COBRA* rate for health coverage.

Special Rules

- All Class I and Class II dependents covered at the time of death of the employee are eligible for continued health coverage through Sandia.
- No new dependents can be added, except for *children* born or adopted with respect to a pregnancy or placement for adoption that occurred before the employee's or retiree's death.
- A survivor cannot add a Class II dependent even if that dependent is a Class I dependent at the time of the employee's death.

Termination Rules

For the surviving spouse and dependents, coverage terminates if:

- The spouse marries
- A surviving spouse dies
- Payment is not received when due

Refer to Section 3, Group Health Plan Premiums, for information on the costs you will pay for surviving spouse/dependent coverage.

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

COBRA

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

COBRA-qualified beneficiaries may continue health coverage through Sandia by notifying Sandia of a qualifying event and by electing *COBRA* coverage and paying the appli-

cable **COBRA** rate in a timely manner for health coverage plus a 2% administrative fee. These individuals are referred to as qualified beneficiaries.

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

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

Qualifying Events Causing Loss of Coverage

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

| You are the qualified beneficiary if you are the... | and if you, a covered member, lose coverage under this Plan due to... | the maximum period of continuation coverage is... |
|---|--|---|
| Spouse Dependent Child | Becoming Medicare entitled (applies to covered employee, retiree, or long-term disability terminnee) Divorce or legal separation of the spouse from the covered employee, retiree, or long-term disability terminnee Death of the covered employee, retiree, or long-term disability terminnee | 36 months |
| Dependent Child | Loss of dependent child status under the plan rules | 36 months |

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

Notification of Election of COBRA

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

| Step | Who | Action |
|------|-------------------------------------|---|
| 1 | Retiree or family member | <p>Notify Sandia Benefits in writing within 60 days after the date on which the following qualifying event occurs:</p> <ul style="list-style-type: none"> • Divorce • Legal separation • Annulment • Loss of a child's dependent status • Disability designation by Social Security <p>Send Notice to:</p> <p>Sandia National Laboratories Attn: Benefits Department, Mail Stop 1022 Albuquerque, NM 87185</p> |
| 2 | Sandia Benefits | Notify Sandia Benefits COBRA Administrator of covered member's qualifying event |
| 3 | Sandia Benefits COBRA Administrator | Notify qualified beneficiaries of their right to continue health coverage through Sandia and how to make an election. The notice must be provided to the qualified beneficiaries within 14 days after the COBRA Administrator receives the notice of a qualifying event. You may contact the COBRA Administrator by calling Sandia HBES at 505-844-4237. |
| 4 | Qualified Beneficiary | <p>Contact the Sandia Benefits COBRA Administrator to elect COBRA coverage.</p> <ul style="list-style-type: none"> • Qualified beneficiary has 60 days to elect COBRA starting from the later of the date he/she is furnished the COBRA rights notice or the date he/she would lose coverage. • Qualified beneficiary must make the initial premium payment within 45 days from the COBRA election date. The plan allows beneficiary a 30-day grace period for monthly premium payment thereafter. • If beneficiary elects to continue coverage, Sandia provides coverage under the Plan at his/her expense plus the applicable administrative fee. • If beneficiary does not elect to continue coverage during the 60-day election period, health coverage under Sandia ends at the end of the month in which the event occurred and the qualified beneficiary became ineligible for coverage. • Failure to make any payment within the payment date requirement described above will cause benefi- |

| Step | Who | Action |
|------|-------------------------------------|--|
| | | <p>ciary to lose all COBRA rights.</p> <ul style="list-style-type: none"> • Following the initial payment, if beneficiary does not pay a premium by the first day of a period of coverage, the plan has the option to cancel his/her coverage until payment is received, and then reinstate the coverage retroactively back to the beginning of the period of coverage. Retroactive reinstatement is not available unless payment is received within 30 calendar days of the due date. • If the amount of payment is wrong, but is not significantly less than the amount due, the plan is required to notify beneficiary of the deficiency and grant a period of no longer than 30 days to pay the difference. The plan is not obligated to send monthly premium notices. |
| 5 | Sandia Benefits COBRA Administrator | Notify qualified beneficiaries of early termination of COBRA continuation coverage if it will end prior to the maximum period that COBRA coverage is available. |

Benefits Under Temporary Continuation Coverage

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

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

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

Termination of Temporary Continuation Coverage

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

- Premiums are not paid in full on a timely basis
- Sandia ceases to maintain any group health plan
- A **qualified beneficiary** begins coverage under another group health plan after electing continuation coverage under Sandia, and that plan does not impose an exclusion or limitation affecting a preexisting condition of the **qualified beneficiary**

- A *qualified beneficiary* becomes entitled to *Medicare* benefits after electing continuation coverage
- A *qualified beneficiary* engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud)

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

Disability Extension and Multiple Qualifying Events

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

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

Section 13. Health Savings Account

Eligibility Overview

The *UHC* High Deductible Plan is defined by law (Tax Code Section 223). While enrolled in the *UHC* High Deductible Plan, members may be eligible to contribute to a Health Savings Account (HSA).

Important

Please note that members are not eligible for an HSA if enrolled under Medicare, can be claimed as a tax dependent on another person's tax return, or are covered by another health plan that is not a qualified high deductible health plan.

HSA Overview

A Health Savings Account is a tax-advantaged account for members covered under a qualified high deductible health plan. Funds in accounts may be distributed to pay for qualified medical expenses. These are expenses for medical care as determined by the IRS that are paid by an individual which are not reimbursable under any health plan coverage. The expenses must be incurred after an HSA has been opened. Examples of qualified medical expenses that can be paid from an HSA:

- Deductibles and coinsurance, and other out-of-pocket associated with medical expenses
- Deductibles and coinsurance, and other out-of-pocket associated with prescription drug expenses
- Some over the counter medications
- Dental and vision expenses
- Some insurance premiums, such as long-term care, COBRA, and, if age 65 or older, other medical premiums (including Medicare) other than for a Medicare supplemental policy such as Medigap coverage

A complete list of qualified medical expenses can be found at IRS website www.treas.gov and in IRS Publications 502 and 969.

Example of Tax Savings Opportunity

| | Without HSA Contributions | With HSA Contribution |
|---------------------------------|---------------------------|-----------------------|
| Gross Annual Income | \$40,000 | \$40,000 |
| Tax-deductible HSA Contribution | \$0 | \$2,400 |
| Taxable Income | \$40,000 | \$37,600 |
| Federal Tax ¹ | \$6,000 | \$5,640 |
| State Tax ¹ | \$2,000 | \$1,880 |
| Annual Net Income | \$32,000 | \$30,080 |

¹Federal and state taxes are estimated and should be used for illustrative purposes only. For more examples of HSA Tax Savings visit the US Department of Treasury website at <http://www.ustreas.gov/offices/public-affairs/hsa/pdf/hsa-examples.pdf>.

HSA Contributions

The maximum annual contribution to an HSA is the lesser of the high deductible plan's deductible or an amount specified by law. Under the *UHC* High Deductible Plan, the maximum is the deductible - \$1,200 for individual coverage and \$2,400 for Family coverage.

Individuals age 55 or older may also make "Catch Up" contributions to an HSA that vary according to year:

- 2006 - \$700
- 2007 - \$800
- 2008 - \$900
- 2009 and after - \$1000

Once an individual is enrolled in Medicare, no further contributions may be made (but distributions from the HSA may continue).

Contributions and investment income accumulated in an HSA are treated on a tax-favored basis. Unused amounts in any one calendar year roll forward to the next year, unlike Flexible Spending Account funds, which generally must be distributed in the same year they were contributed in order to avoid forfeiture.

To contribute to HSA:

- Download a Contribution Form on myuhc.com® to make a deposit.
- Download an ACH Authorization form on myuhc.com and mail the completed form with a voided check to Exante Bank.

Remember: contribute no more than annual limit as specified by the Internal Revenue Service.

HSA Distributions

Distributions for qualified medical expenses can be made on a tax-free basis. A distribution can be made for any of the following individuals:

- The individual covered by the high deductible plan
- A spouse of the individual covered by the high deductible plan (even if the spouse is not covered by the high deductible plan)
- Any other dependent of the individual covered by the high deductible plan (even if the dependent is not covered by the high deductible plan)

Distributions can also be made for non-qualified medical expenses, although the distribution will not be tax-free. Unless the non-qualified distribution is made for an individual who is at least age 65 or who is disabled or who has died, a 10% penalty tax will be applied in addition to ordinary income tax.

The nature (qualified vs. non-qualified) of a distribution does not have to be substantiated at the time of the distribution, but the individual should keep receipts for documentation purposes.

Example

A retiree with family coverage has contributed \$2,400 to an HSA in both 2006 and 2007. No distributions have yet been made from the HSA, and with investment earnings, the account balance is currently \$5,000. The retiree’s spouse has a surgery and incurs out-of-pocket medical expenses from deductible and coinsurance of \$2,100. The retiree is able to withdraw this amount from the HSA to pay for these expenses, and still has \$2,900 in the account for future expenses.

Opening an HSA Account

Many financial institutions have HSAs available. You may open an account at any of these institutions. Or you may make use of United Healthcare’s relationship with Exante Bank. If you establish an HSA at Exante Bank, Sandia will pay the initial account set-up fees.

Exante Health Savings Account (HSA) Schedule of Fees

The table below outlines each fee associated with the Exante Bank HSA, how it may apply to the account and, where possible, how to avoid certain fees in the charge below.

| Fee | Amount | Alternative to Incurring Fee |
|---|--|---|
| Initial Account Setup | None | Waived by UnitedHealth Group® |
| Monthly Maintenance Fee | \$3.00 – This fee includes use of: Health Savings Account Card – to pay charges directly; Online Bill Payment – limit one transaction per business day | If the account balance is below \$5,000, this will appear on bank statement as a fee. |
| ATM Withdrawal with Health Savings Account Card | \$1.50 per transaction – Exante Bank charges a fee to account for making an ATM withdrawal. In addition to Exante’s fee, the bank/ATM used to withdraw funds will charge own fee (variable by bank) for the transaction. | If Health Savings Account Card is used at the point of service (such as a pharmacy), or card number is written on a bill from a provider who accepts MasterCard, ATM fees can be avoided. |
| Check Order Fee | \$1.50 for six checks. | To avoid this fee, use the Health Savings Account Card whenever possible. One may also order checks outside of Exante Bank through another vendor of their choice. |

| Fee | Amount | Alternative to Incurring Fee |
|---|---|--|
| <p>Electronic Funds Transfer (EFT) Fees:</p> <p>ACH Fee (Automated Clearing House) Applies to Withdrawals Only</p> <p>Wire Transfer Fee (wires sent and received)</p> | <p>1st time free per year; thereafter, \$5.00 – An ACH lets one transfer funds from one account to another for availability within the next 2 business days</p> <p>\$20.00 – Money can be moved money electronically from same-day availability when money is needed immediately.</p> | |
| Overdraft Fee | \$25.00 – An overdraft fee will occur as a result of a check, in-person withdrawal, ATM withdrawal or other electronic withdrawal when funds are not available in the HSA. | To avoid an overdraft fee, keep account current, or check myuhc.com for available balance before withdrawing funds. |
| Refund of Excess Contribution | \$20.00 | Contribute no more than the annual limits as specified by the IRS. Total annual contribution includes money contributed by retiree and/or anyone else. |
| Insufficient Funds (for deposit made to your HSA) | \$15.00 | Be sure there are funds available to cover the amount of any check written to make a deposit to HSA. |
| Mailing Bank Forms (that area available on the Web) | 1st one free per year; otherwise, \$5.00 | Forms are available free of charge on myuhc.com. |
| Stop Payment Fee | \$15.00 | Fee incurred only if a request is made to Exante Bank to stop payment on a check or an electronic funds transfer. |
| Research Fee | \$10.00 per hour | Save receipts and use the Health Savings Account Card whenever possible, to avoid research requests. |
| Copy of Debit Card Receipt for Payments | \$25.00 | Save receipts when using the Health Savings Account Card to pay for charges to avoid requests for copies. |
| Reprint of Monthly Statement | \$10.00 per request | Statements are available for up to 12 months at a time on myuhc.com, and may be printed free of charge. |
| Account Closure Fee | \$2.00 | No fee to keep account at Exante Bank. |

Appendix A. Prescription Drug Program

The Prescription Drug Program (*PDP*), is part of the *UHC* HDHP. The program is administered by *UHC* and its subcontractor, Medco. Any licensed provider is legally authorized to prescribe medications to issue your prescription.

In performing its obligation to process and adjudicate claims for plan benefits, UHC is the named claims fiduciary. As the claims fiduciary, UHC has the sole authority and discretion to determine whether submitted claims are eligible for benefits and to interpret, construe, and apply the provisions of the Plan (with the exception of member eligibility provisions which, except for incapacitated dependent status, are determined by Sandia) in processing and adjudicating claims, including appeals. As the claims fiduciary, determinations by UHC shall be conclusive and not subject to review by Sandia. Upon written request and free of charge, any member may examine documents relevant to their claim and/or appeals and submit opinions and comments.

Important

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

The following chart summarizes the *coinsurances* as well as, coverage for purchases under the Mail-Order Program and the UHC network and out-of-network retail pharmacies.

| Mail-Order Program | UHC/Medco Network Retail Pharmacies | Out-of-Network Retail Pharmacies |
|--|---|---|
| For maintenance prescription drugs 20% coinsurance, after deductible, for Tier 1 prescription drugs 20% coinsurance, after deductible, for Tier 2 prescription drugs 20% coinsurance, after deductible, for Tier 3 prescription drugs Maximum of 90-day supply | 20% coinsurance of retail discount price, after deductible, for Tier 1 prescription drugs 20% coinsurance of retail discount price, after deductible, for Tier 2 prescription drugs 20% coinsurance of retail discount price, after deductible, for Tier 3 prescription drugs Maximum of 30-day supply | 30% coinsurance of retail network price, after deductible Maximum of 30-day supply File your claims with UHC Coinsurance does apply to UHC HDHP deductible and out-of-pocket maximum |

Benefit Levels

Benefits are available for outpatient prescription drugs that are considered Covered Health Services.

The Plan pays Benefits at different levels for tier-1, tier-2 and tier-3 prescription drugs. All prescription drugs covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). Since the PDL may change periodically, you can visit **myuhc.com** or call UHC/Medco at the toll-free number on your ID card for the most current information.

Each tier is assigned a *coinsurance*, which is the amount you pay after you have met the annual prescription drug deductible, when you visit the pharmacy or order your medications through home delivery. Your *coinsurance* will also depend on whether or not you visit the pharmacy or use the home delivery service - see the table shown at the beginning of this section for further details. Here's how the tier system works:

Tier-1: For the lowest out-of-pocket expense, you should consider tier-1 drugs if you and your *physician* decide they are appropriate for your treatment.

Tier-2: Consider a tier-2 drug if no tier-1 drug is available to treat your condition.

Tier-3: The drugs in tier-3 are usually more costly. Sometimes there are alternatives available in tier-1 or tier-2.

Assigning Prescription Drugs to the PDL

UHC's Prescription Drug List (PDL) Management Committee makes the final approval of prescription drug placement in tiers. In its evaluation of each prescription drug, the PDL Management Committee takes into account a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include:

- Evaluations of the place in therapy; and
- Relative safety and efficacy.

Economic factors may include:

- The acquisition cost of the prescription drug; and
- The cost effectiveness of the prescription drug.
- The drug's ability to offset medical costs

The PDL Management Committee may periodically change the placement of a prescription drug among the tiers. These changes will not occur more than six times per calendar year and may occur without prior notice to you.

Note: The Prescription Drug List (PDL) is a tool that helps guide you and your Physician in choosing the medications that allow the most effective and affordable use of your prescription drug benefit.

Eligibility

Members eligible for coverage under the *UHC* High Deductible Health Plan are eligible for the *PDP UHC* HDHP members who have primary prescription drug coverage under another group health care plan are not eligible to use the Mail-Order Program or purchase drugs from retail network pharmacies.

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

Identification Cards

If you and your covered dependents are new enrollees in the *UHC* High Deductible Health Plan, your new medical *ID* card will also be used for your *PDP*. You will no longer receive a separate *ID* card for the *PDP*.

Note: If you and your covered dependents were enrolled in the Sandia Top, Intermediate, or Basic *PPO* Plans prior to January 1, 2006, you will receive a new *ID* card for both medical and *PDP*.

The *ID* card identifies you to pharmacies as an eligible Plan member and contains the following:

- Your name
- An identification number assigned by *UHC*
- The group contract number you are enrolled in
- The appropriate processing information needed by the pharmacist
- The claims filing address
- Customer Service phone number

Important

Always present your ID card when obtaining prescriptions at a retail pharmacy.

Covered Prescriptions

Important

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

To be covered, the prescription must be considered a covered health service. The **PDP** covers the following categories of drugs:

- Federal Legend Drugs — A medicinal substance that bears the legend “Caution: Federal Law prohibits dispensing without a prescription”
- State Restricted Drugs — A medicinal substance that, by state law, may be dispensed by prescription only
- Compounded Medications — A compounded prescription in a customized dosage form that contains at least one federal legend drug
- Insulin and Diabetic Supplies — Supplies, including lancets, alcohol swabs, test-strips, and syringes, can be purchased in-network with a prescription and at the applicable deductible/coinsurance, or in-network without a prescription by paying the full price and submitting the claim to UHC/Medco for reimbursement. (You will be reimbursed down to the appropriate benefit level.) The Mail-Order Program is also available for insulin and diabetic supplies purchased with a prescription.

Note: *Medicare* covers lancets and test strips.

- Novopen
- Insulin auto-injectors except for implantable insulin pumps
- Syringes
- Oral contraceptives
- Diaphragms
- Oral calcium supplements for clinically documented hypoparathyroidism
- Niferex
- Prescription smoking-deterrent products prescribed from four weeks to 20 weeks and limited to two courses of therapy per lifetime
- Vaccines (at retail only)
- Prescription vitamins
- Retin A/Renova/Differen
- Viagra (for male participants only), limited to eight pills every 30 days at retail and 24 pills every 90 days by mail

Note: Certain drugs (such as Imitrex, Ritalin, Zomig, Amerge, and Toradol) are subject to quantity restrictions per established UHC clinical guidelines. If the prescription exceeds these clinical quantity restrictions, the **physician** must submit a letter of medical necessity supporting the need for medication beyond the clinical guidelines. UHC reserves the right to challenge any prescription that may put a patient at risk or appears to be a situation of abuse.

Prescriptions Requiring Prior Notification

Before certain prescription drugs are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to notify UHC/Medco. UHC/Medco will determine if the prescription drug is:

- a Covered Health Service as defined by the Plan; and
- not Experimental and Investigational or Unproven, as defined in *Appendix C, UHC HDHP Acronyms and Definitions*.

If UHC/Medco is not notified before the prescription drug is dispensed, you may pay more for that prescription drug order or refill. You will be required to pay for the prescription drug at the time of purchase. If UHC/Medco is not notified before you purchase the prescription drug, you can request reimbursement after you receive the prescription drug.

To determine if a prescription drug requires notification, either visit **myuhc.com** or call the toll-free number on your ID card. The prescription drugs requiring notification are subject to UHC's periodic review and modification.

Non-covered Prescriptions

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

- Over-the-counter medications
- Fluoride preparations, dental rinses, Tri-Vi-Flor
- Contraceptive foams, jellies, and ointments
- Medications that are used for conditions and/or at dosages determined to be Experimental and Investigational, or Unproven, unless UHC/Medco have agreed to cover an Experimental and Investigational or Unproven, treatment, as defined in *Appendix C, UHC HDHP Acronyms and Definitions*.
- Glucose tablets
- Drugs used for cosmetic purposes
- Over-the-counter vitamins and minerals
- Prescription drugs that may be properly received without charge under local, state, or federal programs, including Workers' Compensation

- Refills of prescriptions in excess of the number specified by the *physician*
- Refills dispensed after one year from the date of order by the *physician*
- Prescription drugs purchased for members who are ineligible for coverage under the *UHC* HDHP
- Prescription drugs taken by a donor who is not insured under this *PPO* Plan
- Medicine not for a covered health service for the treatment of a disease or an *injury*
- Medications that are compounded and do not contain at least one ingredient that requires a prescription
- Medications that are comprised of components that are available in over the counter form or equivalent
- Medications that are in excess of any supply limits (days' supply or quantity limit)
- Prescription drugs that are new drugs and/or new dosages, until they are reviewed and assigned to a category by the PDL Management Committee
- Oral non-sedating antihistamines or a combination of antihistamines and decongestants
- Medications that are prescribed, dispensed or intended for use while you are an inpatient in a *hospital, skilled nursing facility* or alternate facility
- Medications that are prescribed to treat infertility
- Medications that are typically administered by a qualified Provider or licensed health professional in an outpatient setting This exclusion does not apply to Depo Provera and other injectable drugs used for contraception
- Medications that are used for cosmetic purposes
- Medications that are used to replace a prescription drug that was lost, stolen, broken or destroyed
- Medications that are used to treat toenail Onychomycosis (toenail fungus)
- Medications that are vitamins, except for the following which require a prescription:
 - prenatal vitamins;
 - vitamins with fluoride; and
 - single entity vitamins.

The following are excluded by the *PDP* but may be covered by *UHC* if a covered health service:

- Medication that is dispensed and/or administered by a licensed facility or provider such as a *hospital*, home health care agency, or *physician's* office, and the charges are included in the facility or provider bill to *UHC*
- Medical supplies such as ostomy supplies, support hose, orthotics, etc.
- Therapeutic devices or appliances such as glucometers and respiratory therapy devices
- Enteral nutrition
- Implantable birth control devices such as Norplant and *IUDs*

- Allergy serum
- Intravenous medications
- Lancet auto-injectors
- Implantable insulin pumps

Mail-Order Program

The Mail Order Program may allow you to purchase up to a 90-day supply of a covered maintenance drug through the mail from a Network Pharmacy. Maintenance drugs help in the treatment of chronic illnesses, such as heart conditions, allergies, high blood pressure, and arthritis.

To use the Mail Order Program, all you need to do is complete a patient profile and enclose your prescription order or refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need a patient profile form, or if you have any questions, you can reach customer service toll-free at the number on your ID card.

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

Important

Prescriptions with dosages that exceed the 90-day supply as determined by UHC/Medco's guidelines will be filled as one 90-day supply and the remainder will be treated as refills. A payment applies for each 90-day prescription and for each refill.

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

If you are a cystic fibrosis patient, you can receive up to a 90-day supply at a Cystic Fibrosis Foundation pharmacy for the applicable mail-order **deductible/coinsurance** by contacting Sandia **HBES** at (505) 844-4237.

Ordering and Receiving Prescriptions

| Step | Action | |
|---|---------------------------------|---|
| 1 | Forms | Obtain a Confidential Mail Service Enrollment Form from the web, Sandia HBES, or the Sandia Line (refer to Appendix E for instructions). |
| 2 | Ordering Original Prescriptions | <p>Complete the Confidential Mail Service Enrollment Form</p> <p>Attach your original written prescription (with your Social Security number and address written on the back). Your physician must write the prescription for a 90-day supply with applicable refills, not a 30-day supply with refills.</p> <p>Enclose the required coinsurance using a check or money order, or a charge card number for Visa, MasterCard, American Express, or Discover/Novus</p> <p>Mail all to Medco Direct, P.O. Box 747000 Cincinnati, OH 45274-70000. Your physician may also call in the prescription to Medco at 1-888-327-9791</p> <p>Note: If you need medication immediately, ask your doctor for two (2) separate prescriptions – one for a 30-day supply to be filled at a network retail pharmacy, and one to be filled by mail service. Wait and send in your mail service prescription two weeks after you fill your prescription at the retail network pharmacy to avoid any delays with your mail service prescription.</p> |
| 3 | Delivery | Expect delivery to your home by first-class mail or second-day carrier within seven to ten working days from the date you mail your order. An adult's signature may be required for acceptance. |
| 4 | Refills | <p>Refilling a mail-order prescription can be done by phone, by fax, by mail, or through the web. It is recommended that you order three weeks in advance of your current mail service prescription running out. Suggested refill dates will be included on the customer receipt that you receive from Medco.</p> <p>Refill-by-Phone: Call 1-888-327-9791 to order refills. You may use the automated refill system 24 hours a day. Customer service representatives are available 24 hours a day, Monday through Friday, and from 8:00 a.m. to 8:00 p.m. (EST) on Saturday, and 9:00 a.m. to 6:00 p.m. (EST) on Sunday. When you call, be ready to provide the primary covered member's Social Security number, prescription number, and a Visa, MasterCard, American Express, or Discover/Novus credit card number.</p> <p>Refill-by-Fax: Complete the Prescription Order Form (attached to the bottom of your customer receipt), making sure you either adhere the refill label provided or write the prescription number in the space provided. Your physician can call 1-888-327-9791 and fax prescriptions directly to the mail order pharmacy. Note: Schedule II prescriptions cannot be faxed.</p> <p>Refill-by-Mail: Complete the Prescription Order Form (attached to the bottom of your customer receipt), making sure you adhere the refill label provided or write the prescription number in the space provided. Mail in the self-addressed, postage-paid envelope.</p> <p>Refill through the Web: Go to www.Medco.com/members and follow the instructions. You will need to use one of the acceptable credit cards for payment.</p> <p>To renew a prescription after all refills have been exhausted follow the instructions listed on the Prescription Renewal Form that is sent by Medco Direct with your last available refill.</p> |
| <p>Note: If you have previously ordered medications through Medco Direct you should use the Prescription Order Form attached to the bottom of your customer receipt sent by Medco with your previous order. If any new drug allergies or medical conditions have developed since your last order indicate this on the back of the Prescription Order Form.</p> | | |

Generic or Brand-to-Brand Substitution

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

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

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

When a brand-name drug becomes available as a generic drug, the tier placement of the brand-name drug may change. You can visit **myuhc.com** or call UHC/Medco at the toll-free number on your ID card for the most current information.

EXCEPTION

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

Retail Network Pharmacies

Retail network pharmacies are available for those members who need immediate, short-term prescription medications, and/or prescription medications that cannot be shipped through the mail. When purchasing a prescription through one of the retail network pharmacies, you will pay the applicable deductible/coinsurance at the time of purchase (see Using the Network Retail Pharmacies, A-11).

UHC has a network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about network pharmacies by contacting UHC at the toll-free number on your ID card or by logging onto **myuhc.com**.

Premier Retail Pharmacy Network Participating Chains

A

A & P Pharmacy
 ACME Pharmacy
 AHS - Providence Pharmacy
 Accredo Therapeutics
 Albertson's Pharmacy
 Allscripts
 Arbor Drug Store
 Arrow Pharmacy & Nutrition Center
 Arrow Prescription Center
 Aurora Pharmacy

B

B & B Pharmacy
 Baker Pharmacy
 Baker's Supermarkets
 Bartell Drugs
 Bashas United Drug
 Bel Air
 Bi-Lo Pharmacy
 Bi-Mart
 Big B
 Bigg's Pharmacy
 Brooks Pharmacy
 Brookshire Brothers Pharmacy
 Brookshire Pharmacy
 Brunos

C

CVS Pharmacy
 Carnival Pharmacy
 Carrs Quality Center
 Cashwise Pharmacy
 City Market
 Coborn's Pharmacy
 Costco PharmacyCub Pharmacy

D

Dillions Pharmacy
 Discount Drug Mart
 Dominicks Pharmacy
 Drug Barn
 Drug Emporium
 Drug Fair
 Drug Mart
 Drug Town
 Drug Warehouse
 Drugs for Less
 Duane Reade

E

Eckerd Drugs
 Econo Foods Pharmacy

F

Fagen Pharmacy
 Fairview
 Family Fare Pharmacy
 Familymeds Pharmacy
 Farm Fresh Pharmacy
 Farmacia El Amal
 Farmer Jack Pharmacy
 Food 4 Less
 Food City Pharmacy
 Food Emporium
 Food Lion Pharmacy
 Food Town
 Food World Pharmacy
 FoodMax Pharmacy
 Fred Meyer
 Fred's Pharmacy
 Fred's Xpress
 Fry's Food & Drug

G

Gerbes
 Giant Eagle Pharmacy
 Giant Pharmacy
 Glen's Pharmacy

H

HEB Pharmacy
 Hannaford Food & Drug
 Happy Harry's
 Harp's Pharmacy
 Harris Teeter Pharmacy
 Hen House Pharmacy
 Homeland Pharmacy
 Hy-Vee Pharmacy
 Hypermart

I

Ingles Pharmacy

J

Jewel-OSCO

K

K Mart Pharmacy
 Kash N Karry Pharmacies
 Keltsch Pharmacy
 Kerr Drug Store
 Kessel
 King Soopers Pharmacy
 King's
 Kinney Drugs
 Kohl's Pharmacy
 Kroger Pharmacy

L

Longs Drug Store
 Lucky

M

Marc's Pharmacy
 Marsh Drugs
 Martin's Pharmacy
 May's Drug Store
 Med-X
 Medic Drugs
 Medicap Pharmacy
 Medistat Pharmacy
 Meijer Pharmacy
 Metro Pharmacy
 Minyard Pharmacy
 More 4 Family Pharmacy
 Mr. Z's Pharmacy

N

Neighborcare
 Network Pharmacy
 Nob Hill Pharmacy
 Nova Factor

O

OSCO

P

P & C Pharmacy
 Pamida Pharmacy
 Pathmark Pharmacy
 Payless Pharmacy
 Pharm
 Pharmacare Pharmacy
 Price Chopper Pharmacy
 Price Cutter Pharmacy
 Publix Pharmacy

Q

QFC Pharmacy
 Quality Markets

R

Raley's
 Ralph's Pharmacy
 Randalls Pharmacy
 Rite Aid

S

Sack 'N Save
 Safeway Pharmacy
 Sam's Pharmacy
 Sav-A-Center Pharmacy
 Sav-On
 Sav-On Pharmacy
 Save Mart Pharmacy
 Schnucks Pharmacy
 Shaw's Pharmacy
 Shop 'N Save
 Shop N Save Pharmacy
 Shopko
 Shoppers Pharmacy
 Shoprite
 Smiths Pharmacy
 Snyder's Drug Store
 St John Pharmacy
 Star Pharmacy
 Stop & Shop
 Sun Mart Pharmacy
 Super 1 Pharmacy
 Super D Drugs
 Super Foodmart Pharmacy
 Super Fresh Pharmacy
 Super G Discount Drug
 Super Sav-on Drugs

T

Talbert
 Target
 The Medicine Shoppe
 Thriftway
 Thirft-White Drug
 Tom Thumb Pharmacy
 Tops Pharmacy
 Tops Pharmacy Services

U

USA Drug
 United Pharmacy

V

Vix Pharmacy
 Vons Pharmacy

W

Wal*Mart Pharmacy
 Waldbaum's Pharmacy
 Walgreens
 Wegmans Pharmacy
 Weis Pharmacy
 White Drug
 Winn-Dixie Pharmacy

X

Xpct Discounts

Independent Pharmacies

Many independent pharmacies are included in the network. Call UHC at the toll-free number on your ID card or by logging onto **myuhc.com** to find out if your neighborhood pharmacy belongs to the network.

Using the Network Retail Pharmacies

To obtain a medication through a retail network pharmacy, you will need a written prescription from your doctor. Present the prescription and *ID* card to the pharmacist. The card is required to identify you as a covered member in order to remit the appropriate payment.

Important

*If you do not show your **ID** card at a retail network pharmacy, you will be required to pay the full non-discounted price and you cannot submit this to the **UHC HDHP claims administrator** or Medco for reimbursement.*

Note: Many pharmacies will process your claim electronically and refund your claim down to your **deductible/coinsurance level** within 7 days of purchase if you forget to show your **ID** card. To obtain a Medco **ID** card, call 1-888-327-9791.

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

Example: You obtain a prescription for a 100-day supply of a generic medication. The pharmacist will fill an initial 30-day supply for the 20% **coinsurance** amount after the deductible is satisfied. Thereafter, the prescription will be filled in monthly intervals, up to a 30-day supply, for the 20% **coinsurance** amount after the deductible is satisfied.

Coinsurance for Prescriptions Purchased in a Network Pharmacy

The amounts for retail network pharmacy prescriptions are located on page A-1. No paper claim filing is required, and **deductible/coinsurance cannot** be submitted to **UHC**, **UBH**, or **Medco** for reimbursement. **Coinsurance** does apply to the **UHC HDHP deductible** or to the **out-of-pocket maximum**. **Coinsurance** is required for each prescription, whether it is an original or a refill.

Using the Out-of-Network Retail Pharmacies

Using an Out-of-Network Pharmacy

If you choose to purchase a prescription through an out-of-network pharmacy, you will be reimbursed 70% after the deductible is satisfied of the retail network price, for up to a 30-day supply. Any amounts over a 30-day supply will be denied.

Filing Claims

If you have a prescription filled by an out-of-network pharmacy, complete a *PDP* Direct Reimbursement Form, attach pharmacy receipts, and send your claim to:

Medco
PO BOX 747000
Cincinnati, OH 45274-70000

Medco will process your claim upon receipt. Once the claim has been processed, the member will receive payment, if applicable, and an *EOB* from Medco, which will include information about the claim (covered, denied, etc.).

Important

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

Timing of Claims Payments

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

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

Urgent Care Claims

Time Frame for Response from Medco

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

Extension

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

Period for Claimant to Complete Claim

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

Other Related Notices

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

Non-urgent Pre-service Claims

Time Frame for Response from Medco

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

Extension

Medco may extend the original time frame by up to 15 days if necessary due to matters beyond the Plan's control. Medco must provide an extension before the initial period ends.

Period for Claimant to Complete Claim

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

Non-urgent Post-service Claims

Time Frame for Response from Medco

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

Extension

Medco may extend the original time frame by up to 15 days if necessary due to matters beyond the Plan's control. Medco must provide an extension notice before the initial period ends.

Period for Claimant to Complete Claim

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

Concurrent Care Claims

Time Frame for Response from Medco

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

Contents of Notice and Response from Medco

The notice will include all of the following:

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

- If the adverse determination is based on a medical necessity or *experimental* treatment or similar exclusion or limit, either an explanation of the specific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Claim Denials and Appeals

If Medco denies your (or a dependent's) claim because of eligibility, see Section 1, Eligibility.

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

| If you have a claim denied because of . . . | then . . . |
|---|---|
| coverage eligibility (except for disability determinations) | Contact Sandia HBES at (505) 844-HBES (4237). |
| benefits administration or any other reason | contact Medco at 1-888-327-9791 |

Filing an Appeal

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

Important

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

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

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

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

Send the written appeal to:

National Appeals Center -

United Healthcare - Appeal
PO Box 30573
Salt Lake City, UT 84130-0573

Two Levels of Appeal

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

Step 1: First Level of Appeal

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

Step 2: Second Level of Appeal

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

Timing of Appeals Decisions

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

- urgent care
- pre-service
- concurrent care
- post-service claim

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

Important

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

Urgent Care Claims

Period for Filing Appeals

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

Note: You do not need to submit *urgent care* claim appeals in writing. You should call Medco as soon as possible to appeal an *Urgent Care* claim.

Time Frame for Response from Medco

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

Non-urgent Pre-service Claims

Period for Filing Appeals

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

Time Frame for Response from Medco

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

Non-urgent Post-service Claims

Period for Filing Appeals

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

Time Frame for Response from Medco

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

If the claimant does not receive a written response from Medco within the time periods described above, the claimant should treat the claim as denied and proceed immediately to the next level of appeal or seek legal recourse.

Appendix B. Members Rights and Responsibilities

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

You have the right to:

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

You have the responsibility to:

- Know and confirm your benefits before receiving treatment.
- Contact an appropriate health care professional when you have a medical need or concern.
- Show your **ID** card before receiving health care services.
- Pay any necessary **coinsurance amounts** at the time you receive treatment.
- Use **emergency** room services only for **injury** or illness that, in the judgment of a reasonable person, requires immediate treatment to avoid jeopardy to life or health.

- Keep scheduled appointments.
- Provide information needed for your care.
- Follow agreed-upon instructions and guidelines of *physicians* and health care professionals.
- Participate in understanding your health problems and developing mutually agreed upon treatment goals.
- Notify Sandia of changes in address or family status.
- Visit *UHC*'s web site (myuhc.com) or call customer service when you have a question about your eligibility, benefits, claims and more.
- Access the web site (myuhc.com) or call customer service to verify that your *physician* or health care professional is participating in the UnitedHealthcare network before receiving services.

Appendix C. UHC HDHP Acronyms and Definitions

Acronyms

| | |
|-----------------|--|
| COB | coordination of benefits (see definition) |
| COBRA | Consolidated Omnibus Budget Reconciliation Act |
| CPR | Corporate Process Requirement |
| DME | durable medical equipment (see definition) |
| EAP | Employee Assistance Program |
| EBC | Employee Benefits Committee |
| EOB | explanation of benefits |
| ERISA | Employee Retirement Income and Security Act |
| HBES | Health, Benefits, and Employee Services |
| HDL | high density lipoprotein |
| HIPAA | Health Insurance Portability and Accountability Act |
| HIV | Human Immunodeficiency Virus |
| HMO | Health Maintenance Organization (see definition) |
| ICD-9 | International Classification of Diseases – the 9 th edition |
| ID | identification |
| IRC | Internal Revenue Code |
| IUD | intrauterine device |
| LDL | low-density lipoprotein |
| LTD Plan | Long-Term Disability Plan |
| NAIC | National Association of Insurance Commissioners |
| PCP | primary care physician |
| PDL | Prescription Drug List |
| PDP | Prescription Drug Program |
| PKU | phenylketonuria |
| PPO | Preferred Provider Organization (see definition) |
| QMCSO | qualified medical child support order |
| SPD | Summary Plan Description |
| TMJ | temporomandibular joint (see definition) |
| UBH | United Behavioral Health |
| UHC | United HealthCare |
| URN | United Resource Networks |

Definitions

| | |
|----------------------------------|--|
| Advance directive | An Advance Directive is a document that states the kinds of health care you want in the event you become unable to make decisions for yourself. |
| Alternate payee/recipient | A child or custodial parent who is not a primary covered member and who, because of a qualified medical child support order (see definition), is entitled to receive a reimbursement directly from the Claims Administrator |
| Behavioral health | Mental health and/or substance abuse |
| Business associates | UHC, CIGNA, Delta Dental, Superior Vision, PayFlex, Mercer Human Resource Consulting, Towers Perrin Consulting |
| Child(ren) | Child(ren) include: <ul style="list-style-type: none">○ the primary covered member's own children and legally adopted children○ adopted child (if the placement agreement and/or final adoption papers have been completed and submitted to Sandia Benefits)○ stepchildren living with the primary covered member (stepchildren visiting for the summer are not considered to be living with you)○ child for whom the primary covered member has legal guardianship○ Natural child, legally adopted child, or child for whom the primary covered member has legal guardianship if a court decree requires the primary covered member to provide coverage |
| Claims administrator | The third party designated by Sandia to receive, process, and pay claims according to the provisions of the UHC HDHP. |
| COBRA | Requires Sandia to offer a temporary extension of health care coverage to primary covered members and dependents who would otherwise lose their group health coverage as a result of certain events |
| Coinsurance | Cost-sharing feature by which both the Plan and the covered member pay a percentage of the covered charge |
| Congenital anomaly | A physical developmental defect that is present at birth |

| | |
|---------------------------------------|---|
| Coordination of benefits (COB) | When a covered member has medical coverage under other group health plans (including Medicare), UHC HDHP benefits are reduced so that total combined payments from all plans do not exceed 100% of the Eligible Expense |
| Cost effective | Least expensive equipment that performs the necessary function. Applies to durable medical equipment and prosthetic appliances/devices. |
| Cosmetic procedures | Procedures or services that change or improve appearance without significantly improving physiological function, as determined by the claims administrator. Reshaping a nose with a prominent bump is an example of a cosmetic procedure because appearance would be improved, but there would be no improvement in function, such as in breathing. |
| Covered health services | Health services and supplies that are: <ul style="list-style-type: none"> • Provided for the purpose of preventing, diagnosing, or treating <i>sickness, injury</i>, mental illness, <i>substance abuse</i> or their symptoms • Included in this SPD (subject to limitations and conditions and exclusions as stated in this <i>SPD</i>) • Provided to a covered member who meets the Plan's eligibility requirements, as described in Section 1 • <i>Medically appropriate</i> |

Custodial care

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

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

Deductible

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

Developmental care

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

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

Dual Sandians

Both spouses are employed by or retired from Sandia National Laboratories

Durable medical equipment (DME)

Equipment determined by UHC to meet the following criteria:

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

Eligible expenses

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

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

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

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

Emergency

See medical emergency

Experimental or investigational

Experimental or investigational drug, device, treatment or procedure means

- a drug or device that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and that has not been approved for marketing at the time the drug or device is furnished
- a drug, device, treatment, or procedure that was reviewed and approved (or that is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function
- a drug, device, treatment, or procedure that is used with a patient informed consent document that was reviewed and approved (or that is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function

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

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

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

(See also “reliable evidence”)

Financially dependent persons

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

Formulary

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

Global charge

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

The determination of what is included in the global charge will be made by the Claims Administrator.

Health Maintenance Organization (HMO)

An affiliation of health care providers offering health care to enrollees

Home health aide services

Include helping the covered member with

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

Hospice

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

Hospital

An institution operated as required by law which is:

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

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

Injury

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

Inpatient stay

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

| | |
|---------------------------------------|---|
| Intensive Outpatient Program | A program that provides 9 to 20 hours per week (less than four hours per day) of professionally directed evaluation and/or treatment |
| Jaw joint disorder (TMJ) | Any misalignment, dysfunction, or other disorder of the jaw joint (or of the complex of muscles, nerves, and tissues related to that joint). It includes temporomandibular joint (TMJ) dysfunction, arthritis, or arthrosis; other craniomandibular joint disorders; and myofascial or orofacial pain syndrome. It does not include a fracture or dislocation that results from an injury. |
| Living with you | A person living in your home at least 50% of the year. Step-children visiting for the summer are not considered to be living with you. |
| Long-term disability terminnee | An employee who has been approved for and is receiving disability benefits under either Sandia's Long-Term Disability Plan or Sandia's Long-Term Disability Plus Plan |
| Maintenance care | Treatment beyond the point where material or significant improvement is to be expected. The treatment results in no measurable or objective improvement. For modality treatments, such as non-surgical spinal treatment or physical therapy, the treatment provides no evidence of lasting benefit; treatment provides only relief of symptoms. |
| Medically appropriate | <p>A service or supply that is ordered by a physician, the medical director, and/or a qualified party or entity selected by UHC and/or UBH, and determined as</p> <ul style="list-style-type: none"> • provided for the diagnosis or direct treatment of an injury or sickness • appropriate and consistent with the symptoms and findings or diagnosis and treatment of the member's injury or sickness • provided in accordance with generally accepted medical practice on a national basis • the most appropriate supply or level of service that can be provided on a cost-effective basis including, but not limited to, inpatient vs. outpatient care, electric vs. manual wheelchair, surgical vs. medical or other types of care • allowable under the provisions of the UHC HDHP as prescribed by the member's physician |

| | |
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| Medical emergency | A sudden and unforeseeable sickness or injury that arises suddenly, and in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health |
| Medicare | A federal program administered by the Social Security Administration that provides benefits partially covering the cost of necessary medical care |
| Medicare eligible | The member is eligible to enroll in Medicare Parts A and B regardless of whether he or she has enrolled. |
| Medicare primary or primary Medicare | The member is eligible to receive Medicare benefits first before Sandia's plan is required to pay, regardless of whether the member has enrolled in Medicare. Medicare primary is the same as primary Medicare. |
| Mental or nervous disorder | Any condition or disease, regardless of its cause, listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association. Not included in this definition are conditions or diseases specifically excluded from coverage. |
| Mid-year election change event | An event that allows a primary covered member to make certain changes to his/her health care coverage. Refer to the Pre-Tax Premium Plan booklet. |
| Morbid obesity | A condition in which an adult has been 100 pounds over normal weight (by the Claims Administrator's underwriting standards) for at least 5 years despite documented unsuccessful attempts to reduce under a physician-monitored diet |
| Network gap exception | If there are no in-network providers in the required specialty within a 30-mile radius from the member's home, UHC will grant an exception to allow in-network benefits for services provided by an out-of-network provider. |
| Non-surgical spinal treatment | <p>Detection or non-surgical correction (by manual or mechanical means) of a condition of the vertebral column, including</p> <ul style="list-style-type: none"> • distortion • misalignment • subluxation <p>to relieve the effects of nerve interference that results from or relates to such conditions of the vertebral column</p> |

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| Open enrollment | The period of time every year when you have the option to change your medical coverage for the subsequent calendar year (normally held in the fall of each year) |
| Out-of-area plan | Members who do not have access to UHC network providers within a 30-mile radius of their home will be covered under the in-network level of benefits under the out-of-area plan when they access providers. UHC determines who will be placed in the out-of-area plan. Reimbursement is based on billed charges. |
| Out-of-pocket maximum | The member's financial responsibility for covered medical expenses before the Plan reimburses additional covered charges at 100%, with no deductible, for the remaining portion of that calendar year |
| Outpatient | A person who visits a clinic, emergency room, or health facility and receives health care without being admitted as an overnight patient (under 24-hour stay) |
| Outpatient surgery | Any invasive procedure performed in a hospital or surgical center setting when a patient is confined for a stay of less than 24 consecutive hours |
| Partial (or day) hospitalization | A program that provides covered services to persons who are receiving professionally directed evaluation or treatment and who spend only part of a 24-hour period (but at least four hours per day) or 20 hours per week in a hospital or treatment center |
| Participating provider | The health care professionals, hospitals, facilities, institutions, agencies, and practitioners with whom UHC and/or UBH contract to provide covered services and supplies to UHC HDHP participants |
| Physician | Any individual who is practicing medicine within the scope of his or her license, and who is licensed to prescribe drugs. The individual must also be acting within the scope of his/her license and performing a service that is payable under this Plan. A physician eligible for reimbursement by this Plan does not include a person who lives with you or is part of your family (you; your spouse; or a child, brother, sister, or parent of you or your spouse). |

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| Plan administrator | Sandia National Laboratories |
| Pre-certification | The process whereby the member calls UBH to obtain prior approval for certain behavioral health services |
| Preferred Provider Organization (PPO) | A network of physicians and other health care providers who are under contract with UHC and/or UBH to provide services for a negotiated fee |
| Prescription Drug List | A list of prescription drugs, as identified by the Claims Administrator, for which the Plan pays benefits. This list is subject to review and modification, no more than six times per year. |
| Prescription Drug List (PDL) Management Committee | A committee that <u>UHC/Medco</u> designates for, among other responsibilities, classifying prescription drugs into specific tiers. |
| 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 retiree, long-term disability terminnee, survivor, or the individual purchasing temporary continued coverage |
| Primary plan | The Plan that has the legal obligation to pay first when more than one health care plan is involved |
| Prior notification | The process whereby the member calls UHC to obtain prior approval for certain medical services |
| Qualified beneficiary | An employee, spouse, or dependent covered the day before the qualifying event, to include a child who is born to or placed for adoption with the covered employee during COBRA. Qualified beneficiaries must be given the same rights as similarly situated employees/beneficiaries. |
| Qualified Medical Child Support Order | A court-ordered judgment, decree, order, or property settlement agreement in connection with state domestic relation law that either (1) creates or extends the rights of an “alternate payee/recipient” (see definition) to receive the reimbursement from the Plan or (2) enforces certain laws relating to medical child support |

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| Reconstructive procedure | A procedure performed to address a physical impairment where the expected outcome is restored or improved function. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a reconstructive procedure |
| Reliable evidence | Any published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, treatment, or procedure; or the written, informed consent used by the treating facility or by another facility studying substantially the same drug, device, treatment, or procedure |
| Residential treatment facility | A residential treatment facility provides acute overnight services for the care of a substance abuse disorder or overnight mental health services for members who do not require acute care. |
| Sandia-sponsored medical plans | <p>For Employees: UHC Premier PPO, CIGNA Premier PPO, UHC Standard PPO, CIGNA In-Network Plan, and Kaiser HMO (CA only)</p> <p>For Non-Medicare members: UHC Premier PPO, CIGNA Premier PPO, UHC High Deductible Health Plan, CIGNA In-Network Plan, and Kaiser HMO (CA only);</p> <p>For Medicare-primary members: UHC Senior Premier PPO, CIGNA Senior Premier PPO, Presbyterian Medicare PPO (NM only), Lovelace Senior Plan (NM only), Kaiser Senior Advantage Plan (CA only).</p> |
| Service area | The geographical area, approved by the appropriate staff agency, within which participating providers are accessible to members |
| Sickness | A disease, disorder, or condition that requires treatment by a physician. For a female member, sickness includes childbirth or pregnancy. The term sickness as used in this SPD does not include mental illness or substance abuse, regardless of the cause or origin of the mental illness or substance abuse. |
| Skilled nursing facility | A nursing facility that is licensed and operated as required by law. A skilled nursing facility that is part of a hospital is considered a skilled nursing facility for purposes of the Plan. |

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| Sound natural teeth | Teeth that <ul style="list-style-type: none"> • are whole or properly restored • are without impairment or periodontal disease • are not in need of the treatment provided for reasons other than dental injury |
| Specialist | Any physician who is devoted to a medical specialty |
| Subrogation | The Plan's or Claims Administrator's right to recover any UHC HDHP payments made because of sickness or injury to you or your dependent caused by a third party's wrongful act or for negligence and for which you or your dependent have a right of action or later recovered said payments from the third party |
| Substance abuse | Abuse by the individual of drugs, alcohol, or other chemicals to the point of addiction, which has been diagnosed as an illness by a licensed physician (this is part of the behavioral health benefit) (see also "mental or nervous disorder") |
| Term of employment | The current period of continuous employment as a regular employee. May include periods of prior service, temporary service, and absence. See CPR 300.6.21. |
| Total disability or totally disabled | Because of an injury or sickness <ul style="list-style-type: none"> • you are completely and continuously unable to perform the material and substantial duties of your regular occupation and are not engaging in any work or occupation for wages or profit • your dependent is <ul style="list-style-type: none"> ○ either physically or mentally unable to perform all of the usual and customary duties and activities (the "normal activities" of a person of the same age and sex who is in good health) ○ not engaged in any work or occupation for wages or profit |

Unproven services

Health services that, according to prevailing medical research, do not have a beneficial effect on health outcomes, and are not based on:

- well-conducted randomized controlled trials
- well-conducted cohort studies

In a randomized controlled trial, two or more treatments are compared to each other, and the patients are not allowed to choose which treatments they receive. In a cohort study, patients who receive study treatment are compared to a group of patients who receive standard therapy. In both cases, the comparison group must be nearly identical to the study treatment group.

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

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

Urgent care

Treatment of an unexpected sickness or injury that is not life threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering such as high fever, a skin rash, or an ear infection.

Urgent care center

Can be attached to a hospital or be freestanding, staffed by licensed physicians and nurses, and providing health care services

Urgent care services

Treatment of a sudden or severe onset of sickness or injury

Important

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

Appendix D. Health Insurance Portability and Accountability Act of 1996

Effective April 14, 2003, a federal law known as the Health Insurance and Portability and Accountability Act of 1996 (*HIPAA*) required that health plans protect the confidentiality of private health information. A complete description of your rights under *HIPAA* can be found in the Plan's privacy notice (see below for further information).

This Plan and Sandia Corporation will not use or further disclose information that is protected by *HIPAA* ("protected health information") without your written authorization except as necessary for treatment, payment, health plan operations, and plan administration, or as permitted or required by law. By law, the Plan will require all of its *business associates* to also observe *HIPAA*'s privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Sandia National Laboratories.

Under *HIPAA*, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under *HIPAA* have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under *HIPAA*'s privacy rules. Privacy notices are distributed to all new members in the Plan and are distributed to current members under a scheduled time table regulated by *HIPAA*. In addition, a copy of this notice is available upon request by contacting Sandia *HBES*. If you have any questions about the privacy of your health information or you wish to file a complaint under *HIPAA*, contact the *HIPAA* Privacy Officer of the Sandia Benefits Department.

Appendix E. UHC PPO Contact Information

Telephone Numbers and Hours of Operation

| Function | Telephone Numbers |
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| UnitedHealthcare – www.myuhc.com | |
| Customer Service – claims questions – check eligibility – benefit information – participating providers – case management | 1-877-835-9855 6:00 a.m. - 8:00 p.m. (MST) Monday - Friday |
| Prior Notification to Care Coordination SM | 1-877-835-9855 6:00 a.m. - 8:00 p.m. (MST) Monday - Friday |
| Pre-certification for certain behavioral health services | 1-877-835-9855 6:00 a.m. - 8:00 p.m. (MST) Monday - Friday |
| Optum Nurse Line | 1-800-563-0416 24 hours a day, 7 days a week |
| On-Site Representative (Bldg. 832 east wing) | 505-844-0657 Walk-ins/appointments: 9:00 a.m. - 3:00 p.m. (MST) Monday - Thursday Messages recorded after hours, on week-ends, and on holidays |
| Healthy Pregnancy Program | 1-800-411-7984 8:00 a.m. - 10:00 p.m. (MST) Monday - Friday |

| Function | Telephone Numbers |
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| UnitedHealthcare – www.myuhc.com | |
| United Resource Networks (URN) Programs – Transplant Resource Services Program – Cancer Resources Services Program – Congenital Heart Disease Resource Services Program – Reproductive Resource Services Program | 1-877-835-9855 1-877-835-9855 1-877-835-9855 1-877-835-9855 |
| UnitedHealthcare Allies Health Discount Program | 1-800-860-8773 www.unitedhealthallies.com |
| Sandia National Laboratories – HBE@sandia.gov | |
| Benefits Customer Service Center (HBES Customer Service Center), Bldg. 832 east-wing/Room 34E – enroll/disenroll in health Plan – forms, i.e., claims, others | New Mexico: 505-844-HBES (4237) or 1-800-41SANDI (417-2634), then dial 844-HBES (4237) Fax: 505-844-7535 8:00 a.m. - 4:30 p.m. (MST) |
| Function | Telephone Numbers |
| In California, Bldg. 925/Rms. 127, 102 | California: 925-294-2254/2073 Fax: 925-294-2392 7:30 a.m. - 4:00 p.m. (PST) |

Obtaining Claim Forms/Envelopes

To obtain **UHC** HDHP claim forms, use any of the following methods:

- Sandia Line: Dial 845-6789, or if you are calling from outside Albuquerque, dial 1-800-417-2634, then 845-6789. Press “9” for quick dial codes.
 - Retirees: press “1088” and “#” and follow instructions
- Sandia Benefits Department: Benefits Customer Service Center, in Albuquerque, Building 832E; Medical Clinic in Livermore
- Obtain forms from UHC @myuhc.com or 1-877-835-9855

Sandia Addresses

| New Mexico | California |
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| Benefits Department 3332, MS 1022 PO Box 5800 Albuquerque, NM 87185 | Personnel & Employee Resources Department 8522, MS 9111 PO Box 969 Livermore, CA 94551-9111 |

