VIA BENEFITS™

Sandia National Laboratories

Your 2024 Sandia Retiree Health Benefits Enrollment Guide

Enroll for 2024 Benefits!

- If you're pre-Medicare-eligible, enroll **Oct. 15-Nov. 10, 2023**
- If you're Medicare-eligible, enroll **Oct. 15-Dec. 7, 2023**

Questions? Call 888-598-7809 (TTY: 711), Monday-Friday, 6 a.m. to 5 p.m. MT

Important Contacts

Medical: If you're pre-Medicare-eligible	
Blue Cross Blue Shield of New Mexico	877-498-7652 bcbsnm.com/sandia
Express Scripts (Prescription Drugs) *(BCBS and UHC medical plans only)*	877-817-1440 (TTY: 800-759-1089) express-scripts.com/sandia
Kaiser Permanente	800-464-4000 healthy.kaiserpermanente.org
UnitedHealthcare	877-835-9855 whyuhc.com/snl
PayFlex (HRA Administration)	aetnaresource.com/payflex/sandia-national-labs
Medical: If you're Medicare-eligible	
UnitedHealthcare Group Medicare Advantage PPO Plan	844-496-0314 uhcretiree.com/sandiaretiree
Humana Group Medicare Advantage HMO Plan	866-396-8810 Monday-Friday, 6 a.m. to 7 p.m. MT humana.com
Kaiser Permanente Group Senior Advantage HMO Plan	800-464-4000 healthy.kaiserpermanente.org
Dental	
Delta Dental of New Mexico	800-264-2818 deltadentalnm.com
Sandia National Laboratories HR Solutions	
For general benefits inquiries	505-284-4700
Via Benefits	
Talk with a benefits advisor to enroll, change coverage, update personal information, and get answers to benefits-specific questions	888-598-7809 (TTY: 711) Monday-Friday, 6 a.m. to 5 p.m. MT sandiaretireebenefits.com (pre-Medicare website) my.viabenefits.com/sandia (Medicare website)

Welcome to

2024 Open Enrollment

During open enrollment, you can:

- Enroll in or change medical and prescription drug coverage.
- Enroll in dental coverage.
- Waive medical and/or dental coverage.
- Add or drop an eligible dependent.

To add a dependent midyear (outside of open enrollment), you must experience a qualifying change in status event, like getting married. For a complete list of qualifying change in status events, refer to the Post-Employment Health & Welfare Summary Plan Description, available at **sandiaretireebenefits.com** (select *Program Summaries/SPDs* at the top of the page). You can drop dependent coverage at any time during the year.

Important: Beginning Jan. 1, 2024, the Your Spending Arrangement (YSA) Program will no longer be available for new retiree enrollments and current Medicare-eligible retirees who are not enrolled in the YSA program. Current pre-Medicare retirees will be allowed to enroll in the YSA program when they become Medicare eligible. If this option is waived, you will not be allowed to enroll in this program in the future. If you want to participate in the YSA program next year or in future years, you should enroll in it this fall.

If you're Medicare-eligible, you must enroll in Medicare Parts A and B to have coverage under the Sandia Retiree Health Plan. Attend an information session for carrier-specific information. Find dates and times at **sandiaretireebenefits.com**.

If you're a Sandia retiree, you must maintain coverage in a Sandia National Laboratories' plan for your spouse and/or dependents to have coverage through Sandia.

About This Guide

The medical and prescription drug information in this guide is separated into two main sections. The first section explains information for pre-Medicare-eligible participants, and the second section explains information for Medicare-eligible participants. Within each of those sections, content will be broken out and color coded for different audiences:

- **Retirees** *(green)*
- **Surviving spouses** *(orange)*
- **LTD terminees** *(purple)*

Use the table of contents on the next page and the tabs across the top of the page to help you find information in this guide.

You can find additional benefit information in the carrier benefit summaries and the Post-Employment Health & Welfare Summary Plan Description (SPD), accessible at sandiaretireebenefits.com. If you want printed copies mailed to you, call Via Benefits at **888-598-7809**.

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What's Changing for 2024

Pre-Medicare Plans

- The deductible and out-of-pocket limit for the Sandia Total Health PPO Plan will increase. For details, go to **pages 20-27**.
- The HRA administration for BCBSNM and UHC plan participants will transition to PayFlex on Jan. 1, 2024.
- The deductible and out-of-pocket limit for the Sandia High Deductible Health Plan (HDHP) will increase. For details, go to **pages 20-25**.
- Premiums will increase for both the Total Health PPO Plan and the High Deductible Health Plan. For details, go to **pages 30-35**.

Medicare Plans

- For new retirees retiring on or after Jan. 1, 2024, the YSA program will no longer be offered. Current pre-Medicare retirees (with a retirement date before Jan. 1, 2024) will be allowed to enroll in the YSA program when they become Medicare eligible. If the YSA option is waived at that time, future enrollment will not be allowed. Medicare-eligible retirees with a retirement date before Jan. 1, 2024, who are interested in electing the YSA program, should enroll in it this fall. Medicare-eligible retirees with a retirement date before Jan. 1, 2024, who do not elect the YSA program during the 2024 Open Enrollment period will not have the option to enroll in the YSA at a future date. If you lose eligibility for the YSA and choose to enroll in an individual Medicare plan with Via Benefits, instead of the Sandia sponsored MAPD, you will not receive any funding or cost offset from Sandia.
- The Sandia-sponsored Kaiser Permanente Group Senior Advantage HMO Plan will be open to new enrollments for a Jan. 1, 2024, effective date (for those living in Northern California).
- Premiums will increase for the Sandia Group Medicare Advantage plans. For details, go to **pages 48-52**.

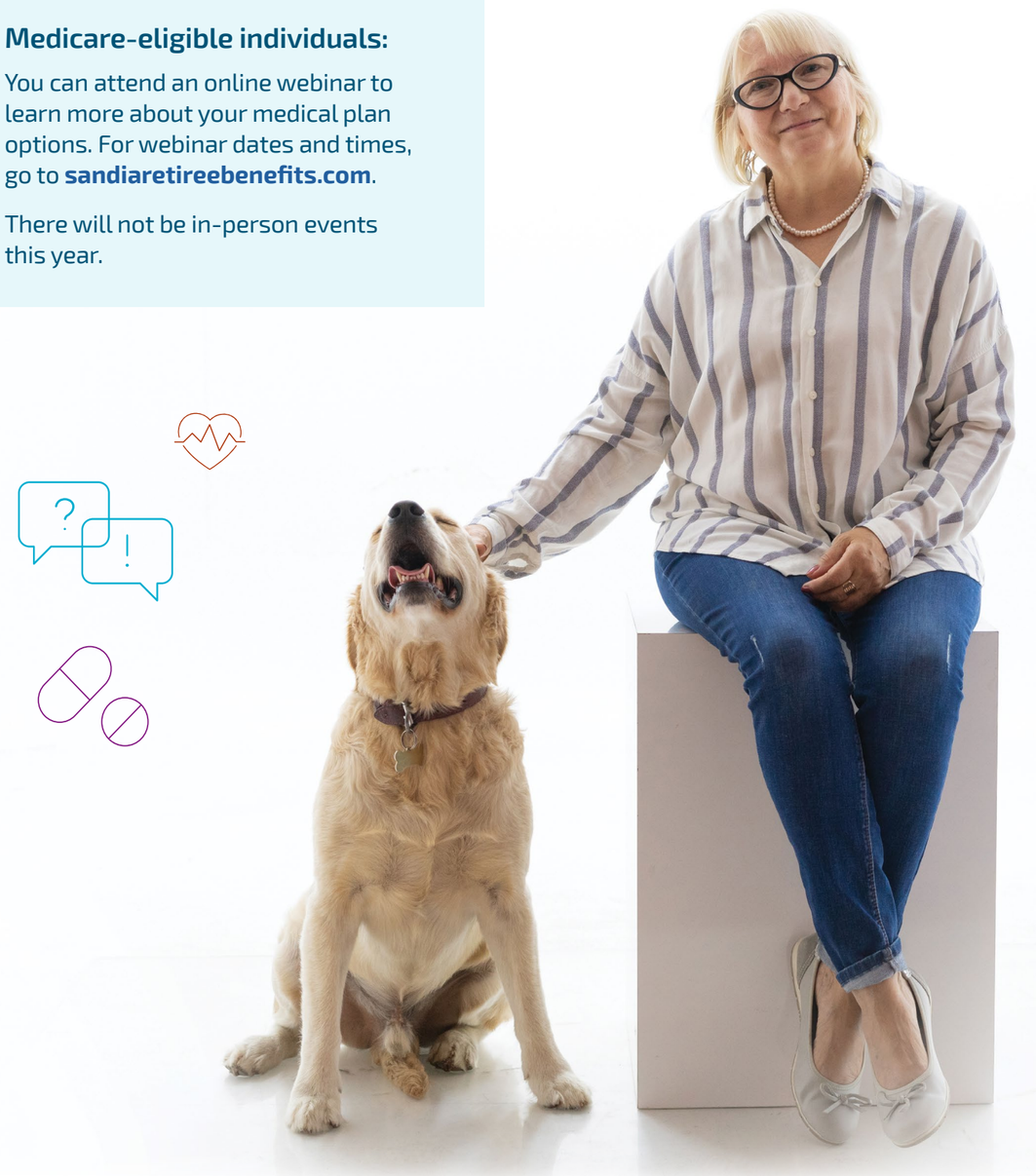
Surviving Spouses

If you're a surviving spouse and currently have medical coverage, you can enroll in the Sandia group-sponsored Dental Care Program with Delta Dental of New Mexico. If you waive this coverage, you will not have another opportunity to enroll in this program in the future.

Medicare-eligible individuals:

You can attend an online webinar to learn more about your medical plan options. For webinar dates and times, go to **sandiaretireebenefits.com**.

There will not be in-person events this year.



Enrolling for Coverage

When to Enroll

- If you're pre-Medicare-eligible, enroll Oct. 15-Nov. 10, 2023
- If you're Medicare-eligible, enroll Oct. 15-Dec. 7, 2023

Before you enroll in or change coverage for 2024, take time to review this guide. If you're **pre-Medicare-eligible**, visit **sandiaretireebenefits.com** for more information. If you're **Medicare-eligible**, visit **my.viabenefits.com/sandia** for individual plan information and Medicare plan enrollment details.

What's Ahead

About Via Benefits

VIA BENEFITS™

Via Benefits Insurance Services will manage the 2024 post-employment health and welfare enrollment for Sandia. When you call Via Benefits, a licensed benefit advisor will help you find and enroll in available medical and dental coverage. Through Via Benefits and at no cost to you, you can search, compare and select plans with the support of unbiased personalized assistance and helpful tools.

Contact **Via Benefits** for help with the following:

- New Medicare-eligible participant enrollment
- Enrollment status and coverage elections
- Address and phone number changes
- Billing statements and payments, and signing up for electronic payments for your Sandia coverage
- Questions about plan eligibility information
- Death notifications and termination of coverage for yourself or dependents
- Power of attorney designations or authorized representatives
- Medicare enrollment in the event of a disability

Via Benefits partners with **Mercer** to help members enrolled in the Sandia group plans. Mercer handles the following:

- Enrollment for new pre-Medicare-eligible retirees
- Monthly premium billing
- Customer service assistance for members enrolled in the Sandia group plans

If you're pre-Medicare-eligible and you call Via Benefits, you will automatically be routed to Mercer for assistance.

Enrolling In, Changing or Waiving Coverage

To make any changes to your benefits — including enrolling in, changing or waiving coverage — call Via Benefits at 888-598-7809 (TTY: 711) to schedule an appointment, or visit the website **my.viabenefits.com/sandia** (if you're Medicare-eligible and enrolled in the YSA).

When you call Via Benefits, the automated telephone system will ask you a few questions; your answers help to secure your call and ensure you're directed to the benefit representative for your specific situation. When responding to questions, speak your answers or use your telephone keypad. Answer the automated questions for the family member who needs assistance (retiree or dependent of the retiree).

Information You Need to Enroll

When you're ready to enroll, you'll need to provide your Social Security number.

If you're Medicare-eligible, in addition to your Social Security number you'll need to provide:

- Your Medicare Parts A and B ID card information.
- A list of the prescription medications you take (name of medication, dosage and format, frequency and quantity).
- The names, addresses and phone numbers of your doctors.

Enrolling Online

(Medicare-Eligible Retirees Only)

To enroll online, you need to create an online account. Follow these steps:

1. Visit **my.viabenefits.com/sandia**.
2. Select *Sign Up*.
3. Enter the requested information on the *Create an account* page and select *Next*.
4. Follow the onscreen instructions. For security purposes, you'll be asked to provide a phone number that Via Benefits will use to call or text a code to you to verify the transaction.

For more information about creating an account, visit **my.viabenefits.com/sandia** > *Menu* > *Help and Support* > *Medicare Help* > search for *Create an account*.

Once you create your profile, you will find a menu of plan options.

Enrolling by Phone

(All Participants)

Call Via Benefits at **888-598-7809** (TTY: 711). Representatives are available to assist you Monday through Friday from 6 a.m. to 5 p.m. MT. Set aside **up to 90 minutes for each person you're enrolling**.

If you're a Medicare participant, you can shorten the call length by creating an online account and updating your information before you call Via Benefits.

On the call, someone will help you complete and submit your application. Two weeks after you submit your application, you will receive a confirmation letter in the mail that verifies your choices.

Paying for Coverage

- **If you enroll in the Your Spending Arrangement (YSA) program:** If you're Medicare-eligible and select the YSA option, you'll receive a YSA guide in the mail within 10 business days of your YSA effective date. The guide will explain how to access funds in your YSA for reimbursement.
- **If you enroll in an individual plan with Via Benefits**, you will set up your premium payments with your carrier of choice, either through direct debit or a monthly invoice.
- **If you enroll in a Sandia group-sponsored plan** (e.g., Sandia's Dental Care Program), you'll receive a billing statement in the mail by mid-December. You can have monthly premium payments automatically deducted from your bank account. If you're already enrolled in the automatic premiums payment process, any premium change(s) will automatically update in January 2024. Automatic premiums are taken on the fifth business day of the month.
- If you don't sign up for automatic payments, please mail your payments to:
  Sandia National Labs
  P.O. Box 77123
  Minneapolis, MN 55480-7702

Keeping Things Organized

If you're Medicare-eligible, you must enroll in Medicare Parts A and B before you contact Via Benefits to enroll in a Medicare plan option.

You will receive new ID cards. It can take four to six weeks to receive your new cards. To check the status of your enrollment, contact Via Benefits. The insurance company issuing your new ID cards may contact you before you receive them. Your coverage for next year is effective Jan. 1, 2024, even if you haven't received your new ID cards.

Keep your address information current. If you need to update your information to ensure you receive important benefits and tax information, call Via Benefits at **888-598-7809** (TTY: 711). Representatives are available to assist you Monday through Friday from 6 a.m. to 5 p.m. MT.

Keep beneficiary information updated. To update your life insurance beneficiary information, complete and return a beneficiary form. You can get a copy of the form in two ways:

1. Visit **prudential.com/mybenefits**.
2. Call **800-778-3827**.

Eligibility

You're eligible for Sandia retiree medical and dental coverage if you're a:

- Pension- and retiree-health-eligible retiree
- Spouse who meets the eligibility requirements as defined in the Post-Employment Health & Welfare Summary Plan Description at **sandiaretireebenefits.com** (select *Program Summaries/SPDs* at the top of the page).
- Dependent child who meets the eligibility requirements
- Surviving spouse who meets the eligibility requirements
- Terminated employee on long-term disability (LTD terminee)

If you're Medicare-eligible, you must enroll in Medicare Parts A and B to have coverage under the Sandia Retiree Health Plan.

If you're a Sandia retiree, you must be enrolled in the medical and/or dental plan through Sandia for your spouse and/or dependents to have coverage through Sandia National Laboratories.

Spouses and Dependent Children

Sandia retirees can cover their:

- Legal spouse
- Children under age 26, including natural children, stepchildren, legally adopted children, and children for whom you have legal guardianship
- Child recognized as an alternative recipient in a Qualified Medical Child Support Order (QMCSO)
- Disabled child (of any age), as determined by the claims administrator

If your spouse and/or dependent is actively employed with Sandia, you cannot cover them under your Sandia retiree medical or dental plan.

Surviving Spouses

If you're a surviving spouse of a Sandia retiree or a surviving spouse of an active on-roll employee who dies, you can enroll in the Surviving Spouse Medical and/or Dental Plan if you were covered by a Sandia medical and/or dental plan at the time of your spouse's death. You can also continue to cover any dependents who were covered at the time of your spouse's death.

You must continue to pay the premiums. If you end your coverage for any reason, you and your dependents cannot return to the plan at a later date. If you remarry, you are no longer eligible for coverage.

You cannot add new dependents to your coverage, except for children born or adopted (including a pregnancy or placement for adoption that occurred) before the employee's or retiree's death.

LTD Terminees

If you became an LTD terminee **before Jan. 1, 2012**, you and your dependents are eligible for pre-Medicare and Medicare medical and dental coverage through Sandia National Laboratories.

If you became an LTD terminee **after Jan. 1, 2012**, you and your covered dependents are eligible for medical coverage through Sandia National Laboratories until you become eligible for Medicare. You and/or your covered dependents will lose medical coverage through Sandia at the end of the month before you and/or your covered dependents become Medicare-eligible. Notify Via Benefits if you and/or a covered dependent becomes Medicare-eligible.

For more eligibility details, refer to the Post-Employment Health & Welfare SPD at **sandiaretireebenefits.com** (at the top of the page, select *Program Summaries/SPDs*).

When a Dependent Becomes Ineligible

Contact Via Benefits at **888-598-7809** within 31 calendar days of any of these events:

- Divorce or annulment
- Legal separation
- Your covered child reaches age 26
- Your covered child (under age 26) becomes incapacitated
- Your covered incapacitated child is no longer incapacitated
- You do not pay your premium
- Your spouse and/or dependent becomes employed by Sandia

Pre-Medicare Medical Plan Options

If you're not Medicare-eligible, you have two medical plan designs to choose from: the Sandia High Deductible Health Plan (Sandia HDHP) and the Sandia Total Health PPO Plan (Total Health PPO). Both plans offer comprehensive medical and prescription drug coverage, no-cost in-network preventive care, and the same provider networks.

The Total Health PPO comes with a Sandia-funded Health Reimbursement Account (HRA) that you can use to help cover out-of-pocket healthcare expenses.

The Sandia HDHP does not come with access to the Sandia HRA or Sandia's Health Savings Account (HSA). Because of IRS rules, Sandia **cannot** contribute to a Health Savings Account (HSA). However, you may be eligible to establish and contribute to an HSA on your own, if eligible. Speak with your tax advisor for more information.

As you decide which plan is the right one for you, consider how the plans are alike and how they differ.

Terms to Know

Annual deductible: The amount you pay out of pocket each year for medical and prescription drug expenses before the plan begins to share costs with you. Your deductible amount depends on which plan you choose, whom you cover and which provider network level you use (Tier 1, 2 or 3).

Coinsurance: The percentage of your covered medical care and prescription drug costs that you pay after your deductible has been met.

In-network providers: A group of healthcare providers and facilities — including doctors, hospitals and labs — that contract with your health insurance plan to provide services at negotiated discount rates. You'll usually pay less when you use an in-network healthcare provider.

Out-of-pocket limit: The most you'll pay out of pocket for covered medical care and prescription drugs during a calendar year. Once you reach this limit, your remaining eligible expenses for the calendar year are covered at 100%.

What's Ahead

Pre-Medicare Plan Highlights

Plan Feature	High Deductible Health Plan	Total Health PPO
Annual deductible	Higher; includes non-preventive medical services and non-preventive prescription drugs	Lower; includes non-preventive medical services; prescription drugs are not subject to the deductible
Annual out-of-pocket limit	Lower; your medical and prescription drug costs accumulate together to meet the out-of-pocket limit.	Higher; your medical and prescription drug costs accumulate separately to meet separate out-of-pocket limits.
Monthly premiums	Lower	Higher
Comes with Health Reimbursement Account (HRA)	No	Yes
Covered services	Both plans offer comprehensive medical and prescription drug coverage* and cover the same services, including in-network preventive care at no cost to you.	
Plan administrator *When you enroll, you choose your plan administrator.*	UnitedHealthcare Blue Cross Blue Shield of New Mexico (BCBSNM)	UnitedHealthcare BCBSNM Kaiser Permanente (Northern California residents only)
Three provider network tiers *You pay less out of pocket when you use Tier 1 or Tier 2 providers. When choosing your plan administrator, see which tier includes your provider.*	**Tier 1:** Outside of New Mexico, Tier 1 providers are available only through UnitedHealthcare; Tier 1 providers are not available to California residents **Tier 2:** Available to all retirees, regardless of where you live **Tier 3:** Out-of-network providers	

Plan Feature	High Deductible Health Plan	Total Health PPO
In-network preventive care	Covered at 100%	Covered at 100%
Non-preventive care	You pay 100% of expenses for non-preventive medical care until you meet the annual deductible, after which the plan shares costs with you. Once you reach the annual out-of-pocket limit, the plan pays 100% of your eligible expenses for the rest of the calendar year.**	

*The PPO pharmacy plan through Express Scripts includes the SaveOnSP specialty medications assistance program; the Sandia HDHP does not.

**The annual deductible and out-of-pocket limit reset each January for the new calendar year.

Plan Administrators and Providers

Provider networks are based on the plan administrator you choose. Your out-of-pocket healthcare costs are determined by your doctor's or provider's network tier, as negotiated with the plan's benefit administrator:

- Tier 1 (specific contracted in-network providers)
- Tier 2 (contracted local, regional and nationwide in-network providers)
- Tier 3 (out-of-network providers)

Depending on where you live, you'll choose from the following:

- Blue Cross Blue Shield of New Mexico (BCBSNM)
- UnitedHealthcare (UHC)
- Kaiser Permanente (available to retirees in Kaiser's Northern California service area only for the Total Health PPO)

You pay less for care when you use in-network (Tier 1 or Tier 2) providers.

If you receive out-of-network care (Tier 3 providers), the plan bases its 60% share of the cost on the allowed charge for a given service. At times, the cost billed by the provider is more than the allowed charge. If this happens, you'll be responsible for your 40% share of the allowed charge (after deductible) plus any balance due, except for services covered by the No Surprises Act described in the carrier's medical plan benefit summary.

Note the following specifics about each plan administrator and its provider networks.

BlueCross BlueShield of New Mexico

BCBSNM

Tier 1: Blue Preferred Plus Network (available in New Mexico only)

Tier 2: National PPO Network (all other states)

Tier 3: Out-of-Network

What you need to know

- Express Scripts administers the prescription drug program. **See pages 24-26**.
- Behavioral health benefits are provided through the BCBSNM Behavioral Health Unit network of providers.
- You need prior authorization for certain medical services, procedures and hospitalizations. You will be responsible for a $300 penalty if you fail to follow the preauthorization process.
- Coverage is available worldwide for emergency and urgent care.
- To find network providers and preauthorization information, visit **bcbsnm.com/sandia**.

UnitedHealthcare

UnitedHealthcare

Tier 1: Choice Plus Premier Provider Network (not available in California)

Tier 2: Choice Plus

Tier 3: Out-of-Network

What you need to know

- Express Scripts administers the prescription drug program. **See pages 24-26**.
- Behavioral health benefits are provided through the United Behavioral Solutions network of providers.
- You need prior authorization for certain medical services, procedures and hospitalizations. You will be responsible for a $300 penalty if you fail to follow the preauthorization process.
- Coverage is available worldwide for emergency and urgent care.
- To find network providers and preauthorization information, visit **whyuhc.com/snl**.

KAISER PERMANENTE®

Kaiser Permanente

In-Network

Out-of-Network

What you need to know

- Kaiser Permanente Pharmacy administers the prescription drug program. **See pages 28-29**.
- You can self-refer to select specialty departments; others require a referral from your primary care provider.
- To be eligible for the plan, you must reside within the Northern California Kaiser Permanente service area and only leave the service area for no more than 6 months. Exception: Students attending school outside the service area.
- Coverage is available worldwide for emergency and urgent care.
- For plan coverage information, review the Kaiser Permanente Benefit Booklet at **sandiaretireebenefits.com**.

Sandia High Deductible Health Plan

With the Sandia High Deductible Health Plan (Sandia HDHP), preventive care and certain preventive medications are free. Preventive care includes services like annual physical exams and certain cancer screenings. The Sandia HDHP offers healthcare premiums that are lower than the Total Health PPO premiums, but the Sandia HDHP annual deductible is higher than the Total Health PPO annual deductible.

With the Sandia HDHP, you have to meet the annual deductible before the plan shares costs with you.

Prescription Drugs

The Sandia HDHP comes with an enhanced prescription drug benefit.

- You pay nothing for generic preventive medications included on the Express Scripts "standard plus" drug list.
- For all other prescription drugs, you pay 100% until you meet your annual combined medical and prescription drug deductible.

The cost of out-of-network prescription drugs purchased outside of the program is covered at 50% after you meet the out-of-network deductible.

A Note about the Health Reimbursement Account (HRA)

The Sandia HDHP does not come with a Health Reimbursement Account (HRA). If you decide to switch from the Total Health PPO to the HDHP during open enrollment, and you have any funds in your current HRA, you will need to use those funds by Dec. 31, 2023, or forfeit the balance on Jan. 1, 2024. Participants have 90 days after the end of the plan year to file claims that were incurred for services during the plan year.

Sandia Total Health PPO

The Sandia Total Health PPO features comprehensive medical and prescription drug coverage — plus it comes with a Sandia-funded Health Reimbursement Account (HRA) that you can use to help cover out-of-pocket healthcare expenses.

Although you'll pay higher monthly premiums for this plan than for the Sandia HDHP, your annual deductible is lower, which means the plan starts sharing costs with you sooner.

Unlike the Sandia HDHP, with this plan, your costs for medical services and prescription drugs accumulate separately to meet separate medical and prescription drug annual out-of-pocket limits. The Total Health PPO has a separate prescription drug out-of-pocket limit of $1,500 per covered individual, up to a total of $5,950 for all family members combined.

Prescription drugs purchased from an out-of-network provider are covered at 50% up to the prescription drug annual out-of-network out-of-pocket limit.

Health Reimbursement Account

Beginning Jan. 1, 2024, administration of the Health Reimbursement Accounts (HRAs) for pre-Medicare BCBSNM and UHC plan participants will transition to PayFlex. Your 2024 annual HRA funds will be with PayFlex, and you will receive a new debit card from PayFlex to access these funds. Kaiser will continue to administer the HRA for Kaiser participants.

Any funds that remain in your current provider's HRA will be transferred to PayFlex by April 30, 2024.

You can use your tax-free HRA to help pay eligible out-of-pocket medical, prescription drug, dental, hearing, vision and other IRS-eligible expenses. Sandia automatically funds your HRA each year, based on your coverage level:

- Retiree only: $250
- Retiree + spouse or child(ren): $500
- Retiree + spouse and child(ren): $750

HRA Funds Rollover

Your HRA rollover is subject to a maximum amount each year. To learn more, visit **sandiaretireebenefits.com**.

If you have HRA funds remaining as of Dec. 31, 2023, you can use these funds with your previous provider for prior year claims up until March 31, 2024. You can't pay for these claims with the HRA debit card. After that date, any remaining funds (up to the maximum amount) will be transferred to your new plan administrator by April 30, 2024.

Note: If you decide to switch from the Total Health PPO to the HDHP during open enrollment, and you have funds remaining in your current HRA, you will need to use those funds by Dec. 31, 2023, or you will forfeit the balance on Jan. 1, 2024. Participants have 90 days following the end of the plan year to file claims that were incurred for services during the plan year.

HRA Funds and Medicare

If you have HRA funds remaining when you become Medicare-eligible at age 65, these funds will transfer to your pre-Medicare spouse or dependent(s) enrolled in the Total Health PPO. If you don't have a pre-Medicare spouse or dependent enrolled in the Total Health PPO, those funds will be forfeited.

Note: The funds transfer is a manual process that can take 60-90 calendar days to ensure that any claims incurred before becoming Medicare-eligible are paid with any available HRA funds. If you are transitioning to Medicare at the end or beginning of the 2024 calendar year, be aware that the funds transfer may not be completed until April 30.

To find more information about your HRA plan, go to **sandiaretireebenefits.com**.

How the Pre-Medicare Plans Compare

Benefits Coverage Administered by BCBSNM, Kaiser and UHC

	High Deductible Health Plan	Total Health PPO
Plan Provider		
You choose one:	• Blue Cross Blue Shield of New Mexico • UnitedHealthcare	• Blue Cross Blue Shield of New Mexico • UnitedHealthcare • Kaiser Permanente
Preventive Care		
	No cost with in-network providers	No cost with in-network providers
Annual Deductible		
Retiree only		
Tier 1 and Tier 2 providers	$1,600	$550 — then coinsurance for Tier 1 providers begins Plus $250 — then coinsurance for Tier 2 providers begins $800 combined maximum
Tier 3 *(out-of-network providers)*	$3,250†	$2,250‡
Retiree + spouse or child(ren)**		
Tier 1 and Tier 2 providers	$3,200	$1,100 ($550 maximum per person) — then coinsurance for Tier 1 providers begins Plus $500 — then coinsurance for Tier 2 providers begins $1,600 — combined maximum
Tier 3 *(out-of-network providers)*	$6,500† (includes deductible)	Up to $4,500 ($2,250 maximum per person)‡

	High Deductible Health Plan	Total Health PPO
Annual Deductible *(continued)*		
Retiree + spouse and child(ren)**		
Tier 1 and Tier 2 providers	$3,200	$1,650 — then coinsurance for Tier 1 providers begins Plus $750 — then coinsurance for Tier 2 providers begins $2,400 — combined maximum
Tier 3 *(out-of-network providers)*	$6,500†	Up to $6,750 ($2,250 maximum per person)‡
Medical Coinsurance *(after deductible)*		
Tier 1 providers	You pay 10%	You pay 10%
Tier 2 providers	You pay 20%	You pay 20%
Tier 3 *(out-of-network providers)*	You pay 40%	You pay 40%

How the Pre-Medicare Plans Compare *(continued)*

	High Deductible Health Plan	Total Health PPO
Annual Out-of-Pocket Limit		
Retiree only		
Tier 1* and Tier 2 providers	$3,250 (combined medical and prescription drug costs — then the plan pays 100%)	**Medical:** $2,250 — then the plan pays 100% for Tier 1 services Plus $750 — then 100% for Tier 2 services $3,000 combined maximum **Separate Limit for Prescription Drugs:** $1,500 per covered individual
Tier 3 providers	$6,500† (includes deductible)	$7,500 (includes deductible)
Retiree + spouse or child(ren)**		
Tier 1* and Tier 2 providers	$9,450 (combined medical and prescription drug costs — then the plan pays 100%)	**Medical:** $4,500 — then the plan pays 100% for Tier 1 services Plus $1,500 — then the plan pays 100% for Tier 2 services $6,000 combined maximum **Prescription Drugs:** $1,500 per covered individual, up to $5,950 for all family members combined
Tier 3 providers	$19,500† (includes deductible)	$15,000 (includes deductible; $7,500 maximum per person)

	High Deductible Health Plan	Total Health PPO
Annual Out-of-Pocket Limit *(continued)*		
Retiree + spouse and child(ren)**		
Tier 1* and Tier 2 providers	$9,450 (combined medical and prescription drug costs — then the plan pays 100%)	**Medical:** $6,750 — then the plan pays 100% for Tier 1 services Plus $2,250 — then the plan pays 100% for Tier 2 services $9,000 combined maximum **Prescription Drugs:** $1,500 per covered individual, up to $5,950 for all family members combined
Tier 3 providers	$19,500†	$22,500 (includes deductible; $7,500 maximum per person)

Note: In- and out-of-network out-of-pocket limits *do not* cross-apply. But the Tier 1 in-network out-of-pocket limit and the Tier 2 in-network out-of-pocket limit *do* cross-apply.

*Tier 1 network is not available in California.

With the **Sandia Total Health PPO, if one person in the family meets the per person-only deductible or out-of-pocket limit listed above, the plan begins to share costs for **that person**. With the **High Deductible Health Plan**, your family members' expenses accumulate together to meet the overall family deductible and out-of-pocket limit amounts noted above. You pay the full amounts before the plan cost sharing begins for any one family member.

†Includes prescription drugs.

‡Does not include prescription drugs.

Prescription Drug Coverage through Express Scripts *(When Enrolled with BCBSNM or UHC)*

	High Deductible Health Plan	Total Health PPO
Your In-Network Annual Deductible		
	You pay the full cost for a medication until you meet the plan's annual deductible* Combined with medical	No deductible applies
Your In-Network Annual Out-of-Pocket Limit*		
	Combined with medical	Separate limits apply for medical and prescription drugs $1,500 per covered individual, up to $5,950 for all family members combined
Your Costs — Retail In-Network Pharmacy or Accredo Specialty Mail Order *(up to a 30-day supply)*		
Generic/specialty generic	$0 for drugs on an expanded list of preventive medications; for other generic drugs, you pay 20% after meeting the deductible ($5 min/$10 max)	You pay 20% ($5 min/$10 max)
Preferred brand/ specialty preferred brand	You pay 30% after meeting the deductible ($30 min/$45 max)	You pay 30% ($30 min/$45 max)
Non-preferred brand/ specialty non-preferred brand	You pay 40% after meeting the deductible ($50 min/$75 max)	You pay 40% ($50 min/$75 max)

	High Deductible Health Plan	Total Health PPO
Your Costs through Express Scripts Mail Order and through the Smart90 Program at Walgreens and CVS *(90-day supply)***		
Generic/specialty generic	$0 for drugs on an expanded list of preventive medications For other generic drugs, you pay 20% after meeting the deductible ($12.50 min/$25 max)	$0 for many medications For other generic drugs, you pay 20% ($12.50 min/$25 max)
Preferred brand/ specialty preferred brand	You pay 30% after meeting the deductible ($75 min/$112.50 max)	You pay 30% ($75 min/$112.50 max)
Non-preferred brand/ specialty non-preferred brand	You pay 40% after meeting the deductible ($125 min/$187.50 max)	You pay 40% ($125 min/$187.50 max)

*Prescription drugs purchased from an out-of-network provider are covered at 50% after the out-of-network deductible has been met.

**Maintenance medications purchased outside of the Smart90 program will be billed at the full cost after the first two months of refills.

What You Need to Know

Prescription drug coverage is the same for BCBSNM and UnitedHealthcare networks. For Kaiser Permanente Sandia Total Health PPO prescription drug coverage, see page 28.

Here are key points to keep in mind:

- If the actual cost of the prescription through the mail or at a retail network pharmacy is less than the copayment, you will pay only the actual cost.
- Under the Express Scripts prescription program, prescriptions will be filled with the least expensive acceptable generic equivalent when available and permissible by law, unless your physician specifies that the prescription is to be dispensed as written.
- Many drugs are subject to step therapy, quantity limits, and/or prior approvals through Express Scripts.
- For specialty medications to be covered by the plan, BCBSNM and UHC members must purchase these drugs through the Express Scripts specialty pharmacy, Accredo. These drugs are delivered via mail order through Accredo.
- All specialty prescriptions will be limited to a 30-day supply and will be subject to the retail coinsurance/copay structure (e.g., 30% coinsurance with a $30 minimum copay and $45 maximum copay for a brand name preferred drug).
- For long-term maintenance medications to be covered, you must have your prescriptions filled using the Express Scripts mail order or Smart90 program. If you do not order your prescriptions through the Express Scripts mail order or Smart90 program, you will be charged the full price for your prescriptions at retail pharmacies after your first two fills.
- View the Express Scripts formulary list and compare drug prices at **express-scripts.com/sandia** during the upcoming 2024 open enrollment period.
- For those participating in the Total Health PPO, Express Scripts provides the SaveOnSP program to help you save money on certain specialty medications. You can find the medications eligible for the program at **saveonsp.com/sandia**. If your specialty medication is included in the SaveOnSP Drug List, you can participate in the SaveOnSP program to receive your medication free of charge ($0). Your prescriptions will continue to be filled through Accredo, your current specialty pharmacy. To enroll or confirm your participation in the SaveOnSP program, call **800-683-1074**.

Sandia Total Health PPO Administered by Kaiser Permanente

	In-Network	Out-of-Network
Preventive Care		
	100% covered (not subject to the annual deductible)	60% covered (you pay 40%)
Your Annual Deductible *(excludes prescription drugs)*		
Retiree only	$800	$2,250
Retiree + spouse or child(ren)	Up to $1,600 ($800 maximum per person)	Up to $4,500 ($2,250 maximum per person)
Retiree + spouse and child(ren)	Up to $2,400 ($800 maximum per person)	Up to $6,750 ($2,250 maximum per person)
Your In-Network Medical Coinsurance		
	You pay 20%	You pay 40%
Your Annual Out-of-Pocket Limit *(excludes prescription drugs)*		
Retiree only *(Prescription drugs: $1,500)*	$3,000 (includes deductible)	$7,500 (includes deductible)
Retiree + spouse or child(ren) *(Prescription drugs: $1,500 per covered individual, up to $5,950 for all family members combined)*	$6,000 (includes deductible; $3,000 maximum per person)	$15,000 (includes deductible; $7,500 maximum per person)
Retiree + spouse and child(ren)	$9,000 (includes deductible; $3,000 maximum per person)	$22,500 (includes deductible; $7,500 maximum per person)

Prescription Drug Coverage Administered by Kaiser Pharmacy

	In-Network	Out-of-Network
Annual out-of-pocket limit	$1,500 per person $5,950 per family	No limit
Prescription Drugs — Retail *(up to a 30-day supply)*		
Generic/specialty generic	You pay 20% (min/max copay: $5/$10)	You pay 50%
Preferred brand/ specialty preferred brand	You pay 30% (min/max copay: $30/$45)	You pay 50%
Non-preferred brand/ specialty non-preferred brand	You pay 40% (min/max copay: $50/$75	You pay 50%
Prescription Drugs — Kaiser Mail Order *(up to a 100-day supply)*		
Generic/specialty generic	You pay 20% (min/max copay: $12.50/$25)	Not available
Preferred brand/ specialty preferred brand	You pay 30% ($75 min/$112.50 max)	Not available
Non-preferred brand/ specialty non-preferred brand	You pay 40% ($125 min/$187.50 max)	Not available

What You Need to Know

- You can view the Kaiser Pharmacy formulary list at **healthy.kaiserpermanente.org**.
- Many drugs are subject to step therapy, quantity limits, and/or prior approvals through Kaiser Pharmacy.
- Maximum of 30-day supply at retail network and out-of-network retail pharmacies.
- Prescription drug copayments and/or coinsurance do not apply to your medical annual deductible or medical out-of-pocket limit.
- If the actual cost of the prescription through the mail or at a retail network pharmacy is less than the copayment, you will pay only the actual cost.
- Under the Kaiser mail order program, your physician must write your prescription for a 100-day supply with refills in 100-day increments.

2024 Pre-Medicare Retiree Monthly Rates

Retirees Who Retired *Before* Jan. 1, 2012

HDHP

Your Monthly Premium Amount							
Years of Service	Pre-1995	Pre-2003	30+	25-29	20-24	15-19	10-14
Member only	$0	$91	$91	$137	$228	$319	$410
Member + 1	$0	$182	$182	$274	$456	$638	$820
Member + 2	$0	$273	$273	$411	$684	$957	$1,230

Total Health PPO

Your Monthly Premium Amount							
Years of Service	Pre-1995	Pre-2003	30+	25-29	20-24	15-19	10-14
Member only	$0	$97	$97	$145	$242	$338	$435
Member + 1	$0	$194	$194	$290	$484	$676	$870
Member + 2	$0	$291	$291	$435	$726	$1,014	$1,305

The monthly premium for a Pre-Medicare Class II dependent is $638 for the HDHP and $677 for the Total Health PPO. To continue to qualify for medical coverage, a Class II dependent must:

- Receive more than 50% of their financial support for the calendar year from the primary member,
- Have a total income of less than $15,000 per year, outside of the support you provide, and
- Have lived in your home, or one provided by you in the United States, during the past six months.

Retirees Who Retired *On or After* Jan. 1, 2012

HDHP

Your Monthly Premium Amount					
Years of Service	30+	25-29	20-24	15-19	10-14
Member only	$211	$250	$328	$405	$483
Member + 1	$422	$500	$656	$810	$966
Member + 2	$633	$750	$984	$1,215	$1,449

Total Health PPO

Your Monthly Premium Amount					
Years of Service	30+	25-29	20-24	15-19	10-14
Member only	$267	$306	$384	$461	$539
Member + 1	$534	$612	$768	$922	$1,078
Member + 2	$801	$918	$1,152	$1,383	$1,617

See next page for 2024 Pre-Medicare Surviving Spouse Monthly Rates »

2024 Pre-Medicare Surviving Spouse Monthly Rates

Surviving Spouses of Employees Who Retired *Before* Jan. 1, 2012

Your Monthly Premium Amount	
HDHP	
Survivor only	$455
Survivor + 1	$910
Survivor + 2	$1,365
Total Health PPO	
Survivor only	$483
Survivor + 1	$966
Survivor + 2	$1,449

Surviving Spouses of Employees Who Retired *On or After* Jan. 1, 2012

Your Monthly Premium Amount		
	Surviving Spouses of Employees with 15 or More Years of Service	Surviving Spouses of Employees with Less Than 15 Years of Service
HDHP		
Survivor only	$522	$911
Survivor + 1	$1,044	$1,822
Survivor + 2	$1,566	$2,733
Total Health PPO		
Survivor only	$578	$967
Survivor + 1	$1,156	$1,934
Survivor + 2	$1,734	$2,901

See next page for 2024 Pre-Medicare LTD Terminee Monthly Rates »

2024 Pre-Medicare LTD Terminee Monthly Rates

Employees Who Became an LTD Terminee *After* Dec. 31, 1994, and *Before* Jan. 1, 2003*

Your Monthly Premium Amount	
	Premium Share for Employees with Monthly Subsidy
HDHP	
Member only	$91
Member + 1	$182
Member + 2	$273
Total Health PPO	
Member only	$97
Member + 1	$193
Member + 2	$290

*If you became an LTD terminee before Jan. 1, 1995, you pay $0 for yourself and any dependents you cover.

Employees Who Became an LTD Terminee *After* Dec. 31, 2002, and *Before* Jan. 1, 2012

Your Monthly Premium Amount		
	Premium Share for Employees with Monthly Subsidy	Premium Share for Employees with Full Premium Share
HDHP		
Member only	$319	$911
Member + 1	$638	$1,822
Member + 2	$957	$2,733
Total Health PPO		
Member only	$338	$967
Member + 1	$677	$1,934
Member + 2	$1,015	$2,901

Employees Who Became an LTD Terminee *On or After* Jan. 1, 2012

Your Monthly Premium Amount		
	Premium Share for Employees with Monthly Subsidy	Premium Share for Employees with Full Premium Share
HDHP		
Member only	$405	$911
Member + 1	$810	$1,822
Member + 2	$1,215	$2,733
Total Health PPO		
Member only	$461	$967
Member + 1	$922	$1,934
Member + 2	$1,383	$2,901

Medicare Medical Plan Options

Medicare-eligible participants can choose one of the Sandia-sponsored Medicare Advantage plans ***or*** the Your Spending Arrangement (YSA) program.* You can elect only one option, not both.

To be eligible for either of these options, you must be enrolled in both Medicare Part A and Part B and continue to pay any applicable Medicare premiums.

Good to Know

Medicare Advantage plans:

- Are also known as Medicare Part C.
- Offer all the benefits of Medicare Part A (hospital coverage) and Medicare Part B (doctor and outpatient care) — plus extra programs like prescription drug coverage.

1 Sandia-Sponsored Medicare Advantage Plans

To elect a Sandia-sponsored Medicare Advantage plan, choose one of these plan options:

- **UnitedHealthcare Group Medicare Advantage PPO Plan** — available nationwide
- **Kaiser Permanente Group Senior Advantage HMO Plan** — available in Northern California
- **Humana Group Medicare Advantage HMO Plan** — available only if you retired prior to Jan. 1, 2012, and you reside in one of these New Mexico counties:
  - Bernalillo
  - San Miguel
  - Sandoval
  - Santa Fe
  - Torrance
  - Valencia

2 Your Spending Arrangement (YSA)*

This is a Sandia-funded account that Medicare-eligible participants can use to pay for an individual Medicare Advantage plan that's purchased on the Medicare exchange through Via Benefits.

If you want to enroll in a Sandia Group Medicare plan or the YSA with an individual Medicare plan, contact Via Benefits at **888-598-7809** (TTY: 711), Monday-Friday, 6 a.m. to 5 p.m. MT.

A representative will help you find a plan that meets your needs.

*If you do not elect the YSA for 2024, it will not be available to you in the future unless you are a current pre-Medicare retiree who becomes Medicare-eligible after Jan. 1, 2024.

What's Ahead

UnitedHealthcare Group Medicare Advantage PPO Plan (including Prescription Drug Coverage)

Available Nationwide

This plan includes comprehensive medical and prescription drug coverage. If you choose this plan, **do not** enroll in another Medicare Advantage plan or another Medicare Part D plan. If you do enroll in another plan, you could lose eligibility for the Sandia plan until the next annual open enrollment period.

Through the UnitedHealthcare Group Medicare Advantage PPO Plan, you have access to a national network of providers. You can see any provider as long as they accept the plan and haven't opted out of or been excluded from Medicare. The plan offers worldwide emergency and urgent care services in the event you are traveling and need medical attention.

> For information about participating providers and covered services, including covered prescription drugs, call UnitedHealthcare at **844-496-0314** (TTY: 711), Monday through Friday from 8 a.m. to 8 p.m. in your time zone, or visit **retiree.uhc.com/sandiaretiree**.

Benefits Coverage through the UnitedHealthcare Group Medicare Advantage PPO Plan

Type of Service	Amount You Pay *(In-Network or Out-of-Network)*
Annual calendar-year deductible	No deductible applies
Annual out-of-pocket maximum	$1,500 per person (combined in-network and out-of-network maximum; does not apply to Part D prescription drugs)
Outpatient Care	
Preventive care *(annual routine physical, certain cancer screenings, vision screening)*	$0
Office visit — primary care provider	$10 copay
Office visit — specialist *(no referral necessary)*	$30 copay
Virtual doctor visit	$10 copay
Urgent care	$10
Emergency room	$50 copay (waived if admitted)
Outpatient surgery	$150 copay
Chiropractic *(manual manipulation of the spine to correct subluxation only)*	$20 copay
Acupuncture	$15 copay (20 visits per year)
Speech, physical and occupational therapy	$10 copay
Outpatient lab and radiology	$0
Inpatient Care	
Hospitalization	$175 per day for days 1-3 (per admission), then $0
Ambulance *(air or ground medical transport)*	$75 copay

Benefits Coverage through the UnitedHealthcare Group Medicare Advantage PPO Plan *(continued)*

Type of Service	Amount You Pay *(In-Network or Out-of-Network)*
Hearing Services	
Exam to diagnose and treat hearing and balance issues	$30 copay
Routine hearing exam	$30 copay
Hearing aids	Through UnitedHealthcare Hearing, the plan pays a $350 allowance for hearing aids (combined for both ears) every 3 years. Hearing aid coverage under this plan is only available through UnitedHealthcare Hearing.
Mental Health	
Inpatient mental health	$175 per day for days 1-3 (per admission), then $0
Outpatient mental health	$30 copay
Outpatient substance abuse	$30 copay

Prescription Drug Coverage through the UnitedHealthcare Group Medicare Advantage PPO Plan

In-Network Coverage Only	
Retail *(30-day supply)*	
Tier 1 *(generic)*	$4 copay
Tier 2 *(preferred brand)*	$20 copay
Tier 3 *(non-preferred brand)*	$40 copay
Tier 4 *(specialty)*	25% coinsurance
Preferred Mail Order *(90-day supply)*	
Tier 1 *(generic)*	$8 copay
Tier 2 *(preferred brand)*	$40 copay
Tier 3 *(non-preferred brand)*	$80 copay
Tier 4 *(specialty; only 30-day supply)*	25% coinsurance

Kaiser Permanente Group Senior Advantage HMO Plan (including Prescription Drug Coverage)

Available Only in Northern California

This plan includes comprehensive medical and prescription drug coverage (Medicare Part D) when you receive care from Kaiser Permanente providers. Non-emergency care from non-Kaiser providers is not covered under this plan unless you've been referred by a Kaiser Permanente physician. If you need specialty care, check with Kaiser Permanente to learn whether you need a referral before receiving care.

If you choose this plan, **do not** enroll in another Medicare Advantage plan or another Medicare Part D plan. If you do enroll in another plan, you could lose eligibility for the Sandia plan until the next annual open enrollment period.

The plan offers worldwide emergency and urgent care services in the event you are traveling and need medical attention.

When you select this plan, Kaiser Permanente provides your regular Medicare benefits. You will automatically be enrolled in the Medicare Part D prescription drug benefit and receive your prescription drug benefits through this plan.

Eligibility

To be eligible for the Kaiser Permanente Group Senior Advantage HMO Plan, you must reside in Northern California within a Kaiser Permanente service area and can only be out of that service area for up to six months per year.

> For information about Kaiser Permanente providers, covered services, and covered prescription drugs, call Kaiser Permanente Member Services at **800-464-4000**, Monday through Friday from 7 a.m. to 7 p.m. PT, and weekends from 7 a.m. to 3 p.m. PT, or visit **healthy.kaiserpermanente.org**.
>
> You can find more information under *Kaiser Senior Advantage* at **sandiaretireebenefits.com**. (At the top of the page, select *Medicare Plans*, then *Group Medicare Plans*. Scroll down the page to *Kaiser Senior Advantage*.)

Benefits Coverage through the Kaiser Permanente Group Senior Advantage HMO Plan

Type of Service	Amount You Pay *(In-Network Only)*
Annual calendar-year deductible	$0
Annual out-of-pocket maximum	$1,000 per person $2,000 per family (two or more) Prescription copays do not apply to the out-of-pocket maximum.
Outpatient Care	
Preventive care *(annual routine physical, certain cancer screenings, vision screening)*	$0
Office visit — primary care provider	$15 copay
Office visit — specialist	$15 copay
Urgent care	$15 copay per visit
Emergency room	$50 copay per visit (waived if admitted within 24 hours with same condition)
Outpatient surgery	$50 copay
Chiropractic	$15 copay (up to 30 visits per year)
Acupuncture	$50 copay
Speech, physical and occupational therapy	$15 copay
Outpatient lab and radiology	$0
Hospital Services	
Hospitalization	$500 copay
Ambulance	$75 copay

Type of Service	Amount You Pay *(In-Network Only)*
Hospice *(inpatient)*	$0
Skilled nursing facility	Days 1-20: $0 Days 21-100: $75 copay per day (Preauthorization required)
Other benefits: Durable medical equipment and external prosthetic appliances	$0
Behavioral Health	
Inpatient mental health	$500 copay
Outpatient mental health	$15 copay
Inpatient and outpatient substance abuse	See Evidence of Coverage at **healthy.kaiserpermanente.org**
Prescription Drugs	
Retail generic	$10 copay for a 30-day supply $20 copay for a 31- to 60-day supply $30 copay for a 61- to 100-day supply
Retail brand name	$20 copay for a 30-day supply $40 copay for a 31- to 60-day supply $60 copay for a 61- to 100-day supply
Mail order generic	$10 copay for a 30-day supply $20 copay for a 31- to 100-day supply
Mail order brand name	$20 copay for a 30-day supply $40 copay for a 31- to 100-day supply
Specialty drugs	See Evidence of Coverage at **healthy.kaiserpermanente.org**

Humana Group Medicare Advantage HMO Plan (including Prescription Drug Coverage)

Available Only to Those Who Retired Before Jan. 1, 2012, and Reside in Select New Mexico Counties

This plan includes comprehensive medical and prescription drug coverage (Medicare Part D). If you choose this plan, **do not** enroll in another Medicare Advantage plan or another Medicare Part D plan; you will automatically be enrolled in the Medicare Part D prescription drug benefit and receive your prescription drug benefits through this plan. If you do enroll in another plan, you could lose eligibility for the Sandia plan until the next annual open enrollment period.

This plan requires that you select a primary care physician (PCP) and let Humana know whom you've selected. If you do not select a PCP, one will be assigned to you. You can change your PCP at any time by calling Humana. When receiving care, you must use Humana providers and facilities in the Humana Medicare HMO network. The Humana HMO plan is an open access HMO, which means you typically do not need to get a referral to see a specialist. But make sure the specialist is in the Humana HMO network. The plan covers emergency and urgent care outside the service area. If you are hospitalized in a non-participating hospital for emergency care, you or a family member must call Humana Customer Care within 48 hours (or as soon as reasonably possible).

Eligibility

To be eligible for this plan, you must have retired before Jan. 1, 2012, and reside in the Humana Medicare HMO service area within New Mexico, which includes these counties:

- Bernalillo
- San Miguel
- Sandoval
- Santa Fe
- Torrance
- Valencia

You must notify Humana and the plan administrator if you move out of the service area.

For a listing of PCPs, specialists, and other providers and facilities, visit **humana.com**. For assistance or to request that a provider directory be mailed to you, call Humana Customer Service at **866-396-8810** (TTY: 711), Monday through Friday, 6 a.m. to 7 p.m. MT.

Benefits Coverage Available through the Humana Group Medicare Advantage HMO Plan

Type of Service	Amount You Pay *(When Using Humana Providers)*
Annual calendar-year deductible	$0
Annual out-of-pocket maximum	$1,500 per person (Does not apply to prescription drug benefits, extra services, or plan premiums)
Outpatient Care	
Preventive care (annual routine physical, certain cancer screenings, vision screening)	$0
Office visit — primary care provider	$10 copay
Office visit — specialist	$30 copay
Urgent care	$30 copay per visit
Emergency room	$50 copay per visit (waived if admitted within 24 hours with same condition)
Outpatient surgery	$150 copay
Chiropractic	Medicare covered: $20 copay Routine: $30 copay (up to 36 visits per year)
Acupuncture	Medicare covered: $30 copay Routine: $15 copay (20 visits per year)
Vision	$0 copay for 1 routine exam per year $150 maximum benefit coverage amount per year for contact lenses, eyeglass lenses and frames, or fitting for eyeglass lenses and frames
Hearing	$20 copay for a routine hearing exam once per year $300 maximum for hearing aids (all types), up to 2 hearing aids per year

Benefits Coverage Available through the Humana Group Medicare Advantage HMO Plan *(continued)*

Type of Service	Amount You Pay *(When Using Humana Providers)*
Outpatient Care *(continued)*	
Speech, physical and occupational therapy	$10 copay
Outpatient lab/radiology	$0
Routine transportation	Up to 4 trips per year covered at 100% for approved locations
Hospital Services	
Inpatient admission	$175 copay per day for days 1-3 per admission (prior authorization required)
Ambulance	$75 copay (limited to emergency Medicare-covered services)
Hospice (inpatient)	Covered by Medicare
Skilled nursing facility	Days 1-20: $0 Days 21-100: $75 copay per day
Other benefits: Durable medical equipment/external prosthetic appliances	$0
Behavioral Health	
Inpatient mental health	$175 copay per day for days 1-3 per admission (prior authorization required)
Outpatient mental health	$20 copay
Inpatient/outpatient substance abuse	$175 copay per day for days 1-3 per admission (prior authorization required)

Type of Service	Amount You Pay *(When Using Humana Providers)*
Additional Benefits	
Postdischarge transportation services	$0 for 12 plan-approved, one-way trips by car, van or wheelchair-accessible vehicle, up to 50 miles per trip. Must be used within 60 days of discharge from an inpatient facility or skilled nursing facility.
Postdischarge personal home care services	$0 for a minimum of 4 hours per day, up to a maximum of 8 hours total per discharge from an inpatient hospital or skilled nursing facility. Personal aides provide assistance with activities of daily living (ADLs) within the home: bathing/showering, dressing, transferring, walking, toileting, and eating. They also offer assistance with instrumental ADLs: preparing meals, grocery shopping, light housework, laundry, dishes, and using the phone/technology. Must be initiated within 30 days of discharge and used within 60 days of discharge.

Prescription Drug Coverage Available through the Humana Group Medicare Advantage HMO Plan

	30-Day Supply *(Retail and Mail Order)*	90-Day Supply *(Retail and Mail Order)*
Tier 1 *(generic or preferred generic)*	$4 copay	$8 copay
Tier 2 *(preferred brand)*	$20 copay	$40 copay
Tier 3 *(non-preferred brand)*	$40 copay	$80 copay
Tier 4 *(specialty drugs)*	25% copay	Not applicable

2024 Medicare Retiree Monthly Rates

Retirees Who Retired *Before* Jan. 1, 2012

UnitedHealthcare Group Medicare Advantage PPO Plan

Your Monthly Premium Amount						
Years of Service	Pre-1995	Pre-2003 and 30+	25-29	20-24	15-19	10-14
Member only	$0	$7.96	$11.95	$19.91	$27.87	$35.84
Member + 1	$0	$15.92	$23.90	$39.82	$55.74	$71.68
Member + 2	$0	$23.88	$35.85	$59.73	$83.61	$107.52

Kaiser Permanente Group Senior Advantage HMO Plan

Your Monthly Premium Amount						
Years of Service	Pre-1995	Pre-2003 and 30+	25-29	20-24	15-19	10-14
Member only	$0	$83.17	$97.03	$124.75	$152.47	$180.19
Member + 1	$0	$166.34	$194.06	$249.50	$304.94	$360.38
Member + 2	$0	$249.51	$291.09	$374.25	$457.41	$540.57

Humana Group Medicare Advantage HMO Plan

Your Monthly Premium Amount						
Years of Service	Pre-1995	Pre-2003 and 30+	25-29	20-24	15-19	10-14
Member only	$0	$7.96	$11.95	$19.91	$27.87	$35.84
Member + 1	$0	$15.92	$23.90	$39.82	$55.74	$71.68
Member + 2	$0	$23.88	$35.85	$59.73	$83.61	$107.52

Retirees Who Retired *On or After* Jan. 1, 2012

UnitedHealthcare Group Medicare Advantage PPO Plan

Your Monthly Premium Amount					
Years of Service	30+	25-29	20-24	15-19	10-14
Member only	$7.96	$11.95	$19.91	$27.87	$35.84
Member + 1	$15.92	$23.90	$39.82	$55.74	$71.68
Member + 2	$23.88	$35.85	$59.73	$83.61	$107.52

Kaiser Permanente Group Senior Advantage HMO Plan

Your Monthly Premium Amount					
Years of Service	30+	25-29	20-24	15-19	10-14
Member only	$83.17	$97.03	$124.75	$152.47	$180.19
Member + 1	$166.34	$194.06	$249.50	$304.94	$360.38
Member + 2	$249.51	$291.09	$374.25	$457.41	$540.57

See next page for 2024 Medicare Surviving Spouse Monthly Rates »

2024 Medicare Surviving Spouse Rates

Surviving Spouses of Employees Who Retired *Before* Jan. 1, 2012

UnitedHealthcare Group Medicare Advantage PPO

Your Monthly Premium Amount	
Survivor only	$39.82
Survivor + 1	$79.64
Survivor + 2	$119.46

Kaiser Senior Group Advantage HMO Plan

Your Monthly Premium Amount	
Survivor only	$194.05
Survivor + 1	$388.10
Survivor + 2	$582.15

Humana Group Medicare Advantage HMO Plan

Your Monthly Premium Amount	
Survivor only	$39.82
Survivor + 1	$79.64
Survivor + 2	$119.46

Surviving Spouses of Employees Who Retired *On or After* Jan. 1, 2012

Your Monthly Premium Amount		
	Surviving Spouses of Employees with 15 or More Years of Service	Surviving Spouses of Employees with Less Than 15 Years of Service
UnitedHealthcare Group Medicare Advantage PPO		
Survivor only	$39.82	$79.64
Survivor + 1	$79.64	$159.28
Survivor + 2	$119.46	$238.92
Kaiser Senior Group Advantage HMO Plan		
Survivor only	$194.05	$277.22
Survivor + 1	$388.10	$554.44
Survivor + 2	$582.15	$831.66

See next page for 2024 Medicare LTD Terminee Monthly Rates »

2024 Medicare LTD Terminee Monthly Rates

Employees Who Became an LTD Terminee *Before* Jan. 1, 2012

Your Monthly Premium Amount		
	Premium Share for Employees with Monthly Subsidy	Premium Share for Employees with Full Premium Share
UnitedHealthcare Group Medicare Advantage PPO Plan		
Member only	$27.87	$79.64
Member + 1	$55.74	$159.28
Member + 2	$83.61	$238.92
Kaiser Permanente Group Senior Advantage HMO Plan		
Member only	$152.47	$277.22
Member + 1	$304.94	$554.44
Member + 2	$457.41	$831.66
Humana Group Medicare Advantage HMO Plan		
Member only	$27.87	$79.64
Member + 1	$55.74	$159.28
Member + 2	$83.61	$238.92

Your Spending Arrangement (YSA) Program

The YSA is a Sandia-funded account that you can use to purchase individual Medicare plans through Via Benefits. **If you do not elect the YSA for 2024, it will not be available to you in the future unless you are a current pre-Medicare retiree who will become Medicare-eligible after Jan. 1, 2024. If you waive or disenroll from YSA coverage, you will not be eligible to enroll in the YSA at a later date. If you lose eligibility for the YSA and choose to enroll in an individual Medicare plan with Via Benefits, instead of the Sandia sponsored MAPD, you will not receive any funding or cost offset from Sandia.**

YSA Eligibility

If you meet the plan's eligibility requirements (**see page 10**), enroll in Medicare Parts A and B, and pay your Medicare premiums, you can use the YSA when you are enrolled in:

- A qualified individual Medicare medical plan through Via Benefits
- TRICARE benefits
- Veterans Affairs (VA) benefits
- A Via Benefits account through Lawrence Livermore National Laboratories

You could also qualify for the YSA if you live in an area with limited or no access to individual Medicare plans through Via Benefits, provided Sandia approves your enrollment.

> When you elect the YSA option, you must purchase your Medicare and/or prescription drug plans through Via Benefits, unless you're enrolled in TRICARE or VA benefits. You ***cannot*** enroll in both a Sandia-sponsored group Medicare Advantage plan and the YSA. You must select one or the other.

Using Your YSA

Via Benefits offers a variety of individual Medicare Advantage, Medigap (also known as Medicare Supplement), and prescription drug coverage options from more than 100 of the nation's largest health insurance companies on its exchange.

When you choose the YSA, **you** — not Sandia — are responsible for choosing your own coverage. Licensed benefit advisors from Via Benefits will help you find cost-effective Medicare coverage that fits your individual needs.

Qualified healthcare expenses that are eligible for reimbursement through the YSA include:

- Medicare Part A (if applicable) and Part B premiums.
- TRICARE insurance premiums.
- Premiums you pay for individual dental plans or the Sandia-sponsored group Dental Care Program.
- Premiums for individual Medicare supplemental insurance purchased through the Via Benefits marketplace, such as individual Medicare Advantage, Medigap, and prescription drug plans.
- Out-of-pocket medical expenses like medical and prescription drug deductibles and copays.

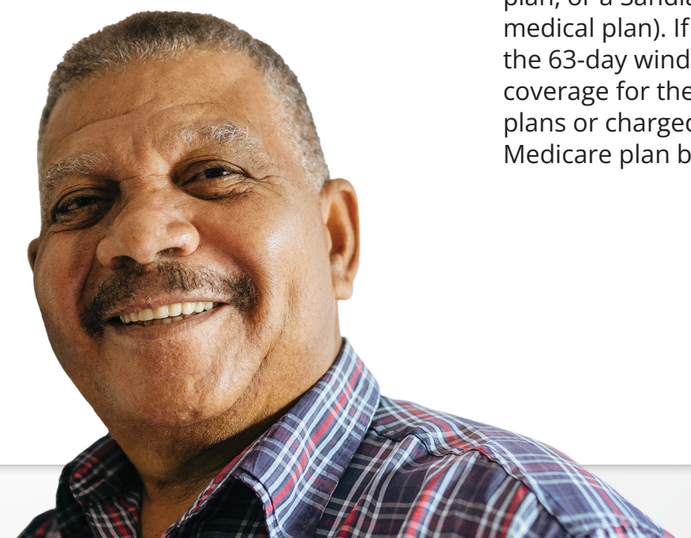
YSA Reimbursements

Some Via Benefits plans offer automatic premium reimbursement. With these plans, you pay your premiums to the insurance carrier for the month or quarter, and the insurance carrier notifies Via Benefits through an electronic file that your payment has been received. This notification triggers a release of payment to you from your available YSA funds; you do not need to file a paper claim form.

Your YSA reimbursements can be deposited directly to your bank account or sent to your address on file with Via Benefits. You'll find direct deposit information in the Via Benefits YSA Guide you receive when you elect this option.

YSA accounts are set up as joint accounts. If your Medicare-eligible spouse elects the YSA option, you and your spouse will have one combined account. Any unused account balance rolls over for use in the next year.

For more information, review the Your Spending Arrangement Program Benefit Summary at **sandiaretireebenefits.com/program-summaries.html**.



Compare Your Options

Via Benefits offers enrollment assistance and advice for selecting from a variety of Medicare and prescription drug coverage options. You can remain in Original Medicare and select a Medigap policy and a Part D prescription drug plan. Or, you can choose an individual Medicare Advantage plan that includes prescription drugs, and use your YSA funds to pay your individual Medicare Advantage plan and Part B premiums.

If you are currently enrolled in an individual plan through the YSA program and want to upgrade your Medigap plan or change carriers, you may be subject to underwriting, which is based on your health condition.

Contact Via Benefits for more information about your plan options. Refer to page 6 for the information you'll need to have available when you're ready to enroll.

Enroll within 63 Days

You must enroll within 63 days from the loss of your Sandia-sponsored group coverage (e.g., a Sandia-sponsored employee plan, an individual group Medicare Advantage plan, or a Sandia-sponsored pre-Medicare medical plan). If you attempt to enroll after the 63-day window, you will be declined coverage for the Sandia-sponsored group plans or charged more for an individual Medicare plan based on your health history.

2024 YSA Annual Credit Amounts for Retirees

2024 YSA Annual Credit Amounts for Retirees

Retirees Who Retired *Before* Jan. 1, 2012						
Years of Service	**Pre-1995**	**Pre-2003 and 30+**	**25-29**	**20-24**	**15-19**	**10-14**
Member only	$2,062	$1,856	$1,753	$1,547	$1,340	$1,134
Member + 1	$4,124	$3,712	$3,506	$3,094	$2,680	$2,268
Member + 2	$6,186	$5,568	$5,259	$4,641	$4,020	$3,402

Retirees Who Retired *On or After* Jan. 1, 2012					
Years of Service	**30+**	**25-29**	**20-24**	**15-19**	**10-14**
Member only	$2,509	$2,364	$2,091	$1,821	$1,535
Member + 1	$5,018	$4,728	$4,184	$3,642	$3,070
Member + 2	$7,527	$7,092	$6,273	$5,463	$4,605

2024 YSA Annual Credit Amounts for Surviving Spouses

Surviving Spouses of Employees Who Retired *Before* Jan. 1, 2012	
Survivor only	$1,031
Survivor + 1	$2,062
Survivor + 2	$3,093

Surviving Spouses of Employees Who Retired *On or After* Jan. 1, 2012	
Survivor only	$1,431
Survivor + 1	$2,862
Survivor + 2	$4,293

2024 YSA Annual Credit Amounts for Medicare LTD Terminees

Employees Who Became an LTD Terminee *Before* Jan. 1, 1995	
Member only	$2,062
Member + 1	$4,124
Member + 2	$6,186

Employees Who Became an LTD Terminee *After* Jan. 1, 1995, and *Before* Jan. 1, 2003	
Member only	$1,856
Member + 1	$3,712
Member + 2	$5,568

Employees Who Became an LTD Terminee *After* Jan. 1, 2003, and *Before* Jan. 1, 2012	
Member only	$1,340
Member + 1	$2,680
Member + 2	$4,020

Employees Who Became an LTD Terminee *On or After* Jan. 1, 2012	
Member only	$1,821
Member + 1	$3,642
Member + 2	$5,463

Dental Care Program

The Sandia Dental Care Program is available to retirees, spouses, and their eligible dependents, as well as to surviving spouses, LTD terminees, and their dependents. The plan is administered by Delta Dental of New Mexico.

Plan Highlights

Here's what you need to know about the dental plan:

- The annual deductible is $50 per individual, up to a maximum of $150 per family.
- The maximum benefit for covered services (excluding orthodontia) is $1,800.
- The lifetime maximum benefit for covered orthodontic services is $1,800.
- The plan includes preventive care security. This means that when you get diagnostic and preventive care from a dentist in the Delta Dental PPO network, you pay nothing, and the services do not count toward the annual maximum benefit paid by the plan.

What's Ahead

What You Pay for Care

Your share of costs varies based on the approved fees for the following types of services and whether or not you use a Delta Dental PPO network provider.

Service Type	Delta Dental PPO Network Providers	Out-of-Network Providers
	You pay:	You pay:
Preventive services *(oral examinations, routine cleanings, and X-rays)*	$0	50% coinsurance after deductible*
Basic and restorative services *(fillings, extractions, endodontic and periodontal services)*	20% after deductible	50% coinsurance after deductible*
Major services *(crowns, prosthodontics, and specified implant procedures)*	45% after deductible	55% coinsurance after deductible*
Orthodontic services *(up to a lifetime maximum)*	50% after deductible	50% coinsurance after deductible*

*These services are subject to balance billing, which means that you'll also pay the difference between what the provider charges for the service and Delta Dental's allowed amount.

Using the Plan

Once you're enrolled in the Dental Care Program, Delta Dental will mail ID cards for all plan enrollees. The card will feature a unique ID number for the primary subscriber and enrolled family member(s).

> **Know Before You Go**
>
> If you or a covered family member needs an extensive or expensive treatment, ask your dental provider for a free pretreatment estimate upfront. It's the best way to avoid big, unexpected (and unwelcome) dental bills.

Cost of Coverage

Your monthly dental premium depends on when you (or your spouse) retired from Sandia, the number of years worked, and whom you're covering.

If You (or Your Spouse) Retired *Before* Jan. 1, 2009		
Retiree	**Surviving Spouse**	**LTD Terminee**
$0 (for individual)	$23 (for individual)	$23 (for individual)
$0 (for individual plus 1)	$46 (for individual plus 1)	$46 (for individual plus 1)
$0 (for 2 or more covered individuals)	$65 (for individual plus 2 or more covered individuals)	$65 (for individual plus 2 or more covered individuals)

If You (or Your Spouse) Were Hired or Rehired *Before* Jan. 1, 2009, and Retired Between Jan. 1, 2009, and Dec. 31, 2011		
Retiree	**Surviving Spouse**	**LTD Terminee**
$11 (for individual)	$23 (for individual)	$23 (for individual)
$23 (for individual plus 1)	$46 (for individual plus 1)	$46 (for individual plus 1)
$32 (for individual plus 2 or more covered individuals)	$65 (for individual plus 2 or more covered individuals)	$65 (for individual plus 2 or more covered individuals)

If You (or Your Spouse) Retired *On or After* Jan. 1, 2012		
Retiree	**Surviving Spouse**	**LTD Terminee**
$46 (for individual)	$46 (for individual)	$46 (for individual)
$92 (for individual plus 1)	$92 (for individual plus 1)	$92 (for individual plus 1)
$129 (for individual plus 2 or more covered individuals)	$129 (for individual plus 2 or more covered individuals)	$129 (for individual plus 2 or more covered individuals)

Note: If you waive medical coverage but elect dental coverage, you will not pay a dental premium.

Required Legal Notices

Women's Health and Cancer Rights Act
(Applies to Pre-Medicare Participants Only)

The medical programs sponsored by Sandia National Laboratories will not restrict benefits if you or your dependent:

- Receives benefits for a mastectomy.
- Elects breast reconstruction in connection with the mastectomy.

Benefits will not be restricted, provided that the breast reconstruction is performed in a manner determined in consultation with your or your dependent's attending physician and you, and may include:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedema.

Benefits for breast reconstruction will be subject to annual deductibles and coinsurance amounts consistent with benefits for other covered services under the program.

Sandia Prescription Drug Program Creditable Coverage Notice
(Applies to Medicare Participants Only)

Sandia National Laboratories Benefits Participant:

Please read this notice carefully and keep it where you can find it.
This notice has information about your current prescription drug coverage with Sandia National Laboratories and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare prescription drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what costs, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

What's Ahead

Two Important Things to Know about Your Current Coverage and Medicare's Prescription Drug Coverage

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan (Part D) or join a Medicare Advantage plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- Sandia National Laboratories has determined that the prescription drug coverage offered by the Sandia Total Health PPO and the Sandia HDHP is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered creditable coverage. Because your existing coverage is creditable coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare prescription drug plan.

Note: The Medicare Advantage plans offered by Sandia National Laboratories provide prescription drug (Part D) coverage. These employer group plans include the UnitedHealthcare Group Medicare Advantage (PPO) Plan, Humana Medicare Advantage Plan (HMO), and Kaiser Permanente Senior Advantage Plan.

This notice does not apply to those enrolled in a Sandia-sponsored Medicare Advantage plan, as you will receive this information from the UnitedHealthcare Plan, Humana Medicare Employer Plan (HMO), or Kaiser Permanente Senior Advantage Plan. In addition, this notice does not apply to those who enroll in the Your Spending Arrangement option.

If you enroll in a Medicare Advantage plan with prescription drug coverage or in a Medicare Part D prescription drug plan through the Your Spending Arrangement option, the plan will send you an explanation of whether or not the prescription drug coverage is creditable. If you do not receive this information, you will need to contact the plan in which you enrolled.

When Can You Join a Medicare Prescription Drug Plan?

You can join a Medicare prescription drug plan when you first become eligible for Medicare and each year between October 15 and December 7.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare prescription drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Prescription Drug Plan?

If you are an active employee or a dependent of an active employee and you and/or your dependents join a Medicare prescription drug plan, you and/or your dependents will still be eligible to receive medical and prescription drug benefits through your active Sandia medical plan as follows:

- If you and your dependents (if applicable) are enrolled in the Sandia Total Health program, you are required to obtain your outpatient prescription drug benefits through your Sandia National Laboratories plan first. You can then file your claims on a secondary basis with your Medicare prescription drug plan.
- If you are a Medicare retiree or a Medicare dependent of a retiree and are enrolled in the UnitedHealthcare Group Medicare Advantage (PPO) Plan, the Humana HMO Employer Group Medicare Plan, or the Kaiser Permanente Senior Advantage Plan, and you enroll in another Medicare prescription drug plan, please note that you may lose your Sandia-sponsored medical plan coverage.

Note: There are exceptions for Medicare plan participants who have end-stage renal disease. Please contact your medical plan carrier for more information.

Important: You can only waive prescription drug coverage by waiving the entire medical plan coverage for yourself and your dependents. Remember, if you waive your coverage, you can only reenroll in the Sandia National Laboratories medical plan:

- During the next open enrollment period with coverage effective Jan. 1 of the following calendar year.
- At any time if you have an eligible midyear election change event.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Prescription Drug Plan?

Important: You should also know that if you drop or lose your current coverage with Sandia National Laboratories and don't join a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare prescription drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) for as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice

Contact Sandia National Laboratories HR Solutions at 505-284-4700.

Note: This notice is available each year for participants in the pre-Medicare medical programs. You can also request a copy through Sandia HR Solutions at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the **Medicare & You** handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.

For More Information about Medicare Prescription Drug Coverage:

- Visit **medicare.gov**.
- For personalized help, call your State Health Insurance Assistance Program (see the inside back cover of your copy of the Medicare & You handbook for their telephone number).
- Call 800-MEDICARE (800-633-4227).
- TTY/TDD users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about the Extra Help program, visit the Social Security Administration website at **ssa.gov** or call **800-772-1213** (TTY: 800-325-0778).

Remember: *Keep this Creditable Coverage Notice. If you decide to join one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).*

Date: October 1, 2023
Name of Entity/Sender: Sandia National Laboratories
Contact–Position/Office: HR Solutions
Address: 1515 Eubank SE, Albuquerque, NM 87123
Phone Number: 505-284-4700

HIPAA Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, whom we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on the back page. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, by calling 1-877-696-6775, or by visiting **hhs.gov/hipaa/filing-a-complaint**. • We will not retaliate against you for filing a complaint.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	**Example:** A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.	**Example:** We use health information about you to develop better services for you.
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	**Example:** We share information about you with your dental plan to coordinate payment for your dental work.
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	**Example:** Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, visit **hhs.gov/hipaa/index**.

Help with public health and safety issues	We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy laws.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

NTESS does not sell or share health information to marketers.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information, visit **hhs.gov/hipaa/for-individuals/index.html**.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you.

This Notice of Privacy Practices applies to the following organizations.

NTESS
Health Plans Benefits Manager
PO Box 5800 Mail Stop 1502
Albuquerque NM 87185-0100

Notice about Nondiscrimination and Accessibility Requirements

Discrimination Is Against the Law

National Technology and Engineering Solutions of Sandia, LLC (NTESS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. NTESS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

NTESS:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact the Health Plans Benefits Manager.

If you believe that NTESS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Health Plans Benefits Manager, PO Box 5800, Mail Stop 1502, Albuquerque, NM, 87185-0100, 505-284-4700, snlbenefits@sandia.gov.

You can file a grievance in person or by mail or email. If you need help filing a grievance, please contact HR Solutions at 505-284-4700 for assistance.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **hhs.gov/hipaa/filing-a-complaint**.

The NTESS Health and Welfare Benefits Plan for Retirees ("the Plan") is maintained at the discretion of NTESS. The NTESS Board of Managers (or designated representative) reserves the right to amend (in writing) any or all provisions of the Plan (or any Benefit Program under the Plan), and to terminate (in writing) the Plan (or any Benefit Program under the Plan) at any time without prior notice. If the Plan (or a Benefit Program under the Plan) is terminated, coverage for you and your dependents will end, and payments under the Plan will generally be limited to covered expenses incurred before the termination. For example, the Plan cannot be modified by written or oral statements to you from HR Solutions or an outside vendor such as Via Benefits/Mercer personnel.

Notes

Sandia National Laboratories

Questions? Call 888-598-7809 (TTY: 711), Monday-Friday, 6 a.m. to 5 p.m. MT