



Sandia National Laboratories

# National Technology & Engineering Solutions of Sandia, LLC (“NTESS”) Health Benefits Plan for Retirees Summary Plan Description

(Retirees, Survivors, and Long-Term Disability Terminees)

Revised: January 1, 2019

## IMPORTANT

This Summary Plan Description (including documents incorporated by reference) applies to Retirees, Surviving Spouses of employees and Retirees, and Long-Term Disability Terminees, effective January 1, 2019.

The National Technology & Engineering Solutions of Sandia, LLC “NTESS” Health Benefits Plan for Retirees is maintained at the discretion of the National Technology & Engineering Solutions of Sandia, LLC. (“NTESS”). The NTESS Health Benefits Plan for Retirees is expected to continue indefinitely. However, the NTESS Board of Managers (or designated representative) reserves the right to amend (in writing) any or all provisions of the NTESS Health Plan for Retirees, and to terminate (in writing) the NTESS Health Plan for Retirees at any time without prior notice. If the Plan is terminated, coverage under the Plan for you and your dependents will end, and payments under the Plan will generally be limited to covered expenses incurred before the termination.

The NTESS Health Benefits Plan for Retirees’ terms cannot be modified by written or oral statements to you from human resources representatives or from the NTESS Health Plans personnel or any other Sandia personnel or Via Benefits/Mercer personnel.



U.S. DEPARTMENT OF  
**ENERGY**



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# Section 1. Introduction

This Summary Plan Description (SPD) is intended to provide a summary of the principal features of the National Technology & Engineering Solutions of Sandia, LLC “NTESS” Health Benefits Plan for Retirees. Additional information about component Programs included in the NTESS Health Plan for Retirees is found in [Appendix E: Program Summary Materials & Evidence of Coverage\(s\)](#). NTESS is also known as “Sandia.”

These component medical Programs for Retirees, Surviving Spouses, and Long-Term Disability Terminees who are not yet Medicare-eligible are the [Sandia Total Health Program administered by UnitedHealthcare](#), the [Sandia Total Health Program administered by Blue Cross and Blue Shield of New Mexico](#), and the [Sandia Total Health Program administered by Kaiser Permanent Insurance Company](#).

For Medicare-eligible Retirees who retired on or before December 31, 2011, the component medical programs are the Sandia-sponsored Medicare Advantage plans as follows: Humana Medicare Employer HMO Plan, UnitedHealthcare Group Medicare Advantage PPO Plan, and the Kaiser Senior Advantage Plan, or alternatively the [Your Spending Arrangement \(YSA\) Program](#).

For Medicare-eligible Retirees who retired on or after January 1, 2012, the component medical program is the YSA Program.

For Medicare-eligible Surviving Spouses of an employee who deceased in 2011 or earlier, the component medical programs are the Sandia-sponsored Medicare Advantage plans as follows: Humana Medicare Employer HMO Plan, UnitedHealthcare Group Medicare Advantage PPO Plan, and the Kaiser Senior Advantage Plan, or alternatively the YSA Program (only if employee had fifteen (15) years or more of service).

For certain Medicare-eligible Surviving Spouses of employees, with fifteen (15) years or more Term of Employment, who deceased in 2012 or later, the component medical is the YSA Program.

For Medicare-eligible Surviving Spouses of an employee who retired on or before December 31, 2011, the component medical programs are the Medicare Advantage plans as follows: Humana Medicare Employer HMO Plan UnitedHealthcare Group Medicare Advantage PPO Plan, and the Kaiser Senior Advantage Plan or alternatively the YSA Program.

For certain Medicare-eligible Surviving Spouses of employees who retired on or after January 1, 2012, the component medical program is the YSA Program.

For certain Medicare-eligible Long-Term Disability Terminees who became an LTD Terminee prior to 2012, the component medical programs are the Medicare Advantage plans as follows: Humana Medicare Employer HMO Plan, UnitedHealthcare Group Medicare Advantage PPO Plan, and the Kaiser Senior Advantage Plan or alternatively the YSA Program.

For certain Medicare-eligible Long-Term Disability Terminees who became an LTD Terminee on or after January 1, 2012, the component medical program is the YSA Program.

For most retirees, the [Dental Care Program](#) is available.

The [Affinity Vision Discount Program](#) is available only to the following:

- Retirees
- Spouses
- Class I Dependents

Long-Term Disability Terminees, Surviving Spouses, Surviving Dependents and Class II Dependents are NOT eligible for the Affinity Vision Discount program.

The Program materials, Evidence of Coverage(s), and updates (for example, Summaries of Material Modifications and open enrollment materials) are referenced in [Appendix E: Program Summary Materials & Evidence of Coverage\(s\)](#). For detailed information on the Programs, refer to the Program Summaries or the Evidence of Coverage(s).

This SPD should be read in connection with the Program Summaries or Evidence of Coverage(s). (See [Appendix E: Program Summary Materials & Evidence of Coverage\(s\)](#)). The Evidence of Coverage(s) is provided by the insurance companies, HMOs and service providers. If there is ever a conflict or a difference between what is written in this SPD and the Program Summaries or Evidence of Coverage(s) with respect to **the specific benefits provided**, the Program Summary or Evidence of Coverage(s) shall govern unless otherwise provided by any federal and state law. If there is a conflict between the Program Summaries and this SPD with respect to **the legal compliance requirements of ERISA and any other federal law**, this SPD will rule.

In general, this Summary Plan Description will cover eligibility; events allowing enrollment and disenrollment; Program premiums; general information; coordination of benefits; claims and appeals information; when coverage ends; continuation of group health coverage; and your rights under ERISA for the medical and/or dental Programs offered by Sandia to its Retirees, Surviving Spouses, and Long-Term Disability Terminees. Specific information will be covered in the applicable Program materials or Evidence of Coverage(s).

Certain capitalized words in this SPD have special meaning. These words have been defined in [Section 14: Definitions](#).

To receive a paper copy of this SPD (including Program Summaries and other documents incorporated by reference), please contact Via Benefits at 888-598-7809 (TTY: 866-508-5123). To receive a paper copy of the Evidence of Coverage(s), please contact the applicable insurance company. This SPD (including documents incorporated by reference) also is available electronically at <http://hr.sandia.gov/#/view/page/plan-documents>.

This SPD will continue to be updated. Please check back on a regular basis for the most recent version.

## Section 2. Summary of Changes

This section highlights clarifications and changes made to the Sandia Health Plan for Retirees effective January 1, 2019:

- Administrative language changes have been made for clarification throughout the document.
- The Presbyterian Senior Care HMO POS changed to the UnitedHealthcare Group Medicare Advantage Plan .

## Section 3. Information about Via Benefits

Sandia has contracted with Via Benefits from Towers Watson to provide all Retiree health benefit administration services for Sandia Retirees, Surviving Spouses, and Long-Term Disability Terminees. Via Benefits is a leading provider of Retiree health benefit administration services. They are not an insurance carrier.

Via Benefits provides licensed benefit advisors who will provide individualized telephone support to help you make an informed decision regarding your health benefit options. In addition, they will manage the Retiree Open Enrollment process. Any changes you wish to make during open enrollment will be handled by Via Benefits.

Via Benefits will manage any changes that you require as a result of mid-year events, such as adding a new Spouse or disenrolling a dependent due to a death.

Via Benefits will assist employees who are transitioning to retirement with their ongoing Retiree health benefits.

Via Benefits will provide eligibility information to the PreMedicare plans as well as to the group Medicare plans. If a Medicare participant enrolls in health coverage through Via Benefits' Your Spending Arrangement (YSA) Program, Via Benefits will process the application for you.

Via Benefits provides Medicare individuals with assistance resolving claim issues.

Via Benefits will be responsible for collecting any group health plan premiums you owe.

Via Benefits also partners with Payflex to handle the claim reimbursement for the Your Spending Arrangement (YSA) Program.

Via Benefits can be reached from 7:00 a.m. to 7:00 p.m. MT Monday through Friday by calling 888-598-7809 (TTY 866-508-5123).

The website for Sandia Group Sponsored Plans and PreMedicare Retirees is [www.SandiaRetireeBenefits.com](http://www.SandiaRetireeBenefits.com).

The website for Medicare Retirees is [My.ViaBenefits.com/Sandia](http://My.ViaBenefits.com/Sandia).



## Section 4. Eligibility Information

This section outlines Retiree, Surviving Spouse, and Long-Term Disability Terminee eligibility for the medical and dental Programs, dependent eligibility guidelines, information on Qualified Medical Child Support Orders (QMCSO), proof of dependent status, events causing dependent ineligibility, consequences of not disenrolling ineligible dependents in the required time frame, special rules for Medicare Primary Covered Members, and provision for covered members with End Stage Renal Disease.

### Retiree Medical Plan Option

You are eligible for continued medical and dental coverage through Sandia if you meet one of the following criteria:

- You were a non-represented employee upon retirement and were hired or Rehired prior to January 1, 2009 and you retired with a service or disability pension.
- You were a non-represented employee upon retirement and were hired or Rehired on or after January 1, 2009 and you meet the age and service requirements then in effect under the Retirement Income Plan (RIP).\*
- You were an OPEIU-represented employee upon retirement and were hired or Rehired prior to July 1, 2009 and you retired with a service or disability pension.
- You were an OPEIU-represented employee upon retirement and were hired or Rehired on or after July 1, 2009 and you meet the age and service requirements then in effect under the Pension Service Plan (PSP) for service eligibility.\*
- You were an MTC-represented employee upon retirement and were hired or Rehired prior to July 1, 2010 and you retired with a service or disability pension.
- You were an MTC-represented employee upon retirement and were hired or Rehired on or after July 1, 2010 and you meet the age and service requirements then in effect under the PSP for service eligibility.\*
- You were an SPA-represented employee upon retirement and were hired or Rehired prior to July 1, 2010 and you retired with a service or disability pension.
- You were an SPA-represented employee upon retirement and were hired or Rehired on or after July 1, 2010 and you meet the age and service requirements then in effect under the PSP for service eligibility.\*

\* Upon becoming Medicare Eligible, the Retiree and/or eligible dependents will not have access to medical or dental coverage through Sandia. If your dependent(s) are PreMedicare, they will have access to Sandia-sponsored medical coverage by paying 100% of the cost but will lose the Sandia-sponsored dental coverage. If any of your dependents become Medicare Eligible prior to you, as the Retiree, they will not have access to medical coverage through Sandia. However, you and/or your eligible

dependents will be able to utilize Via Benefits to assist you in purchasing individual Medicare plans and/or dental coverage.

**IMPORTANT:** If you are hired or Rehired at Sandia after your initial retirement and subsequently retire again, your medical, dental premium-share and YSA amounts will be based on the plan in place at the time of your Rehire date.

If you are enrolled in the Vision Care Program as an employee, you will remain covered until the end of the month in which you retire. You will have the option to continue vision coverage for a limited period of time under COBRA. Refer to [Section 12: Continuation of Group Health Coverage](#), for more information. In addition, you are eligible for the vision discount program through Davis Vision. You can call Davis Vision at 888-575-0191 or go to [hr.sandia.gov](http://hr.sandia.gov) and search [Davis Vision Affinity Discount Program](#) for more information.

If you are eligible for pension payments but have elected to defer your pension payments you are not eligible for continued medical and dental coverage through Sandia under the Retiree Medical Plan Option until you elect to begin to receive pension payments. Upon election to receive your pension payments, you have 31 calendar days from the issuance of your first pension payment to elect coverage. If you do not elect within those 31 calendar days, you will have to wait until Open Enrollment to enroll, with coverage effective the first day of the following calendar year.

In addition, if you retire from Sandia and you are hired (or rehired) by Sandia's Parent Organization (Parent Organization is any company that owns 80% of Sandia's stock. Currently, it is Honeywell International you are not eligible for continued medical and dental coverage through Sandia under the Retiree Medical Plan Option.

If you work for the Parent Organization and continue to receive a pension from Sandia and you are between 65-70 ½ you can only work 40 hours per month to continue in the Sandia Retiree Medical Program.

Upon your re-retirement from Sandia's Parent Organization, you will be subject to the medical and dental benefits/premium-sharing that are in place at the time of your original retirement.

**IMPORTANT:** Your medical, dental premium-share, YSA amounts will be based on the plan in place at the time you elect to begin to receive pension payments. For example, if you retire in 2011, have 30+ years of service, and are eligible for medical coverage at the 10% rate, if you defer your pension payments until 2019 and you are PreMedicare, you will be subject to the medical dental premium-share, and YSA amounts in place for those who retire in 2019.

Refer to [Section 6: Program Premiums](#), for information on the costs you will pay for coverage as a Retiree and [Section 11: When Coverage Ends](#), for information on when medical and dental benefits end.

**IMPORTANT:** Surviving Spouses (and dependents) will not be able to elect the Surviving Spouse Medical Plan Option if you (the Retiree) die and your Surviving Spouse (and dependents) are not covered as a dependent under your Sandia-sponsored medical plan at the time of your death.

As an alternative to electing coverage under the Retiree Medical Plan Option upon retirement, you may elect to temporarily continue the same health coverage as available to active employees by making an election under COBRA. Refer to Coverage through COBRA for more information. If you elect COBRA coverage instead of coverage under the Retiree Medical Plan Option, you cannot elect the Retiree Medical Plan Option after your COBRA coverage has terminated.

If you elect the Retiree Medical Plan Option, you waive your rights to COBRA. As it is an either/or option.

**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.

### **Surviving Spouse Medical Plan Option**

**IMPORTANT:** If you are covered under the medical plan through the Retiree, upon the death of the Retiree, contact Via Benefits if you would like to continue coverage through the Surviving Spouse Medical Plan option. If you are covered under the medical plan through an employee, upon the death of the employee, Sandia will notify Via Benefits on your behalf.

#### **If you are a Surviving Spouse of:**

- an on-roll regular non-represented employee who hired or Rehired in prior to January 1, 2009
- an on-roll regular OPEIU-represented employee who hired or Rehired in prior to July 1, 2009
- an on-roll regular MTC- or SPA-represented employee who hired or Rehired in prior to July 1, 2010

who dies while covered under one of the medical Programs, you (and any enrolled dependents) are eligible to continue PreMedicare and Medicare medical coverage through Sandia through the Surviving Spouse Medical Plan Option. Coverage will continue under the employee until the end of the month in which the employee dies. If the Surviving Spouse Medical Plan Option is selected, coverage will begin under the applicable medical Program the first of the following month in which the employee deceases.

#### **If you are a Surviving Spouse of:**

- an on-roll regular non-represented employee who hired or Rehired in on or after January 1, 2009;
- an on-roll regular OPEIU-represented employee who hired or Rehired in on or after July 1, 2009;
- an on-roll regular MTC or SPA-represented employee who hired or Rehired in on or after July 1, 2010;

...and the employee dies while covered under one of the medical Programs, you (and any enrolled dependents) are eligible to continue ONLY PreMedicare medical coverage through

Sandia through the Surviving Spouse Medical Plan Option. Upon becoming Medicare Eligible, coverage for the Surviving Spouse and any enrolled dependents will be discontinued. If any of your dependents become Medicare Eligible prior to you, as the Surviving Spouse, they will not have access to medical coverage through Sandia. However, you and/or your eligible dependents will be able to utilize Via Benefits to assist you in purchasing individual Medicare plans and/or dental coverage.

**If you are a covered Surviving Spouse of an employee, who retired prior to 2012,** who dies while covered under one of the medical Programs, you (and any enrolled dependents) are eligible to continue PreMedicare and Medicare medical coverage through Sandia through the Surviving Spouse Medical Plan Option. Coverage will continue under the Retiree until the end of the month in which the Retiree dies. If the Surviving Spouse Medical Plan Option is selected, coverage will begin under the applicable medical Program the first of the following month in which the Retiree deceases.

**If you are a covered Surviving Spouse of an employee, who retired on or after January 1, 2012,** and the employee was:

- a non-represented employee upon retirement and was hired or Rehired prior to January 1, 2009 and retired with a service pension
- an OPEIU-represented employee upon retirement and was hired or Rehired prior to July 1, 2009 and retired with a service pension
- an MTC- or SPA-represented employee upon retirement and was hired or Rehired prior to July 1, 2010 and retired with a service pension

...and the Retiree dies while covered under one of the medical Programs, you (and any enrolled dependents) are eligible to continue PreMedicare and Medicare medical coverage through Sandia through the Surviving Spouse Medical Plan Option. Coverage will continue under the Retiree until the end of the month in which the Retiree dies. If the Surviving Spouse Medical Plan Option is selected, coverage will begin under the applicable medical Program the first of the following month in which the Retiree passes.

**If you are a covered Surviving Spouse of an employee who retired on or after January 1, 2012,** and the employee was:

- a non-represented employee upon retirement and was hired or Rehired on or after January 1, 2009 and met the age and service requirements then in effect under the RIP for service eligibility
- an OPEIU-represented employee upon retirement and was hired or Rehired on or after July 1, 2009 and met the age and service requirements then in effect under the PSP for service eligibility
- an MTC- or SPA-represented employee upon retirement and was hired or Rehired on or after July 1, 2010 and met the age and service requirements then in effect under the PSP for service eligibility

...and the Retiree dies while covered under one of the medical Programs, you (and any enrolled dependents) are eligible to continue ONLY PreMedicare medical coverage through Sandia

through the Surviving Spouse Medical Plan Option. Upon becoming Medicare Eligible, coverage for the Surviving Spouse and any enrolled Medicare dependents will be discontinued. If any of your dependents become Medicare Eligible prior to you, as the Surviving Spouse, they will not have access to medical coverage through Sandia. However, you and/or your eligible dependents will be able to utilize Via Benefits to assist you in purchasing individual Medicare plans and/or dental coverage.

**Note:** If applicable, dental and vision coverage will be offered under the COBRA provisions as outlined in [Section 12: Continuation of Group Health Coverage](#).

### ***Special Rules***

- All Class I and PreMedicare Class II Dependents, covered at the time of death of the employee or Retiree, are eligible for continued medical coverage through Sandia. If the Class II dependent is Medicare, the Class II dependent is not eligible for coverage.
- 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.

Refer to [Section 6: Program Premiums](#), for information on the costs you will pay for coverage as a Surviving Spouse and [Section 11: When Coverage Ends](#), for information on when medical benefits end.

As an alternative to electing coverage under the Surviving Spouse Medical Plan Option, you may elect to temporarily continue the same health coverage as available to active employees or retirees (whichever is applicable) by making an election under COBRA. Refer to [Coverage through COBRA](#) for more information. If you elect COBRA coverage instead of coverage under the Surviving Spouse Medical Plan Option, you cannot elect the Surviving Spouse Medical Plan Option after your COBRA coverage has terminated. If you elect the Surviving Spouse Medical Plan Option, you must waive your rights to COBRA as it is an either/or option.

### **Long-Term Disability Terminee Medical Plan Option**

If you terminate employment because of a disability and you are approved for and receiving Long-Term Disability benefits under the Long-Term Disability/Plus Plans through Sandia and you are:

- an on-roll non-represented employee who hired or Rehired in prior to January 1, 2009
- an on-roll OPEIU-represented employee who hired or Rehired in prior to July 1, 2009
- an on-roll MTC- or SPA-represented employee who hired or Rehired in prior to July 1, 2010

...you are eligible for continued PreMedicare and Medicare medical coverage through Sandia until the end of the month in which you recover and the Plan benefit ceases, the Plan benefit ceases for any other reason, or you die.

If you terminate employment because of a disability and you are approved for and receiving Long-Term Disability benefits under the Long-Term Disability/Plus Plans through Sandia and you are:

- a non-represented employee who hired or Rehired in on or after January 1, 2009
- an OPEIU-represented employee who hired or Rehired in on or after July 1, 2009
- an MTC or SPA-represented employee who hired or Rehired in on or after July 1, 2010

...you are eligible for continued PreMedicare medical coverage through Sandia until the end of the month in which you recover and the Plan benefit ceases, the Plan benefit ceases for any other reason, you die, or you become Medicare Eligible. Coverage for you and any enrolled dependents will be discontinued. If any of your dependents become Medicare Eligible prior to you, as the Long-Term Disability Terminatee, they will not have access to medical coverage through Sandia.

Refer to [Section 6: Program Premiums](#), for information on the costs you will pay for coverage as a Long-Term Disability Terminatee and [Section 11: When Coverage Ends](#), for information on when medical benefits end.

As an alternative to electing coverage under the Long-Term Disability Terminatee Medical Plan Option upon termination, you may elect to temporarily continue the same medical coverage as available to active employees by making an election under COBRA. Refer to COBRA in this section for more information. If you elect COBRA coverage instead of coverage under the Long-Term Disability Terminatee Medical Plan Option, you cannot elect the Long-Term Disability Terminatee Medical Plan Option after your COBRA coverage has terminated. If you elect the Long-Term Disability Terminatee Medical Plan Option, you must waive your rights to COBRA as it is an either/or option.

**Note:** If applicable, dental and vision coverage will be offered under the COBRA provisions as outlined in [Section 12: Continuation of Group Health Coverage](#).

## **No Duplicate Coverage**

You may not be covered by a medical, dental, or YSA Program provided by Sandia as an employee or Retiree (or Long-Term Disability Terminatee) and as an eligible family member of another primary covered Sandia employee or Retiree (or Long-Term Disability Terminatee) at the same time.

Dependents of Dual Sandians who have legally separated, divorced, or had an annulment cannot be covered under both parent's medical or dental Programs. If you are covered as an eligible family member and then become eligible for medical or dental coverage as Retiree or Long-Term Disability Terminatee, you have two options:

- Waive the Retiree or Long-Term Disability Terminatee coverage, or
- Make sure that the Sandia employee or Retiree (or Long-Term Disability Terminatee) who has been covering you disenrolls you from his or her Sandia medical or dental program before you enroll yourself.

If Sandia discovers double coverage, Sandia reserves the right to:

- Cancel the later enrollment.
- Retroactively terminate dependent coverage, effective the end of the month in which the dependent became ineligible.
- Hold the Primary Covered Member personally liable to refund to Sandia all health benefit claims or premiums paid by Sandia (for insured programs) during the ineligible period.

## Eligible Dependents

This section outlines eligibility for dependent coverage under the medical and dental Programs. In order for the dependent to have coverage, the Primary Covered Member must also be enrolled.

Sandia provides coverage for two classes of dependents: Class I dependents and Class II Dependents.

**Note:** Class II dependents are no longer eligible to enroll effective as follows: January 1, 2009 for retirees and non-represented employees; March 1, 2009 for OPEIU-represented employees; and January 1, 2010 for MTC- and SPA-represented employees.

You must enroll your Class I dependent within 31 calendar days (60 calendar days for a birth, adoption, or placement for adoption) of the event creating eligibility. Refer to [Section 5: Enrollment/Disenrollment Events](#), for enrollment information and coverage effective dates. If you enroll your dependent(s) for coverage effective prior to the 17th of the month, you are required to pay the applicable cost-share amount for the month for coverage under the applicable Sandia medical and dental Programs. If you enroll your dependent(s) for coverage on the 17th of the month or later, you are not required to pay the cost-share amount for the month for coverage under the applicable Sandia medical and dental Programs.

**Note:** Surviving Spouses cannot enroll new dependents as Class I dependents 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.

## Proof of Dependent Status

To verify eligibility for your covered dependents under the Sandia Health Plan for Retirees, Sandia, insurance carriers, third party administrators or other third parties designated by Sandia, may request documentation needed to verify the relationship, including but not limited to birth certificates, adoption records, marriage certificates, Social Security number, and tax documentation.

In addition, Sandia may request information from you regarding Medicare eligibility and enrollment, address information, Social Security number, and more. You are required to promptly provide the requested information.

***Sandia reserves the right to disenroll Retirees, Surviving Spouses, and Long-Term Disability Terminees, and their covered dependents, for failing to provide documentation when requested. In addition, Retirees, Surviving Spouses, and Long-Term Disability Terminees who***

*have ineligible dependents enrolled in the medical or dental Programs may be subject to other consequences as outlined under Failure to Disenroll Class I Dependents.*

**IMPORTANT:** If your dependent has not worked enough to qualify for Medicare Part A on their own, your dependent can purchase Medicare Part A. However, if your dependent does not qualify for no-cost Part A due to insufficient Medicare-covered employment, once you turn 62, your dependent is then eligible for Part A at no cost, and you must purchase Medicare Part A. If you are under age 62 and your dependent is not a US citizen, and therefore is unable to purchase Medicare, your dependent can enroll into one of the PreMedicare medical plans until becoming a US citizen and eligible to purchase Medicare.

If you enroll for coverage, you may also enroll your eligible dependents as a Class I dependent in your medical and dental Program as outlined in the table below:

Dependent Category	Eligibility	Must Meet All Applicable Requirements
Sandia will generally disenroll your dependent at the end of the month in which your child turns 26. If your dependent was not automatically disenrolled, please notify Via Benefits to disenroll. (See <a href="#">Section 12: Continuation of Group Health Coverage</a> , for additional information.)		
Spouse	To any age	<ul style="list-style-type: none"> <li>• Not legally separated or divorced from you</li> <li><b>Note:</b> An annulment also makes the Spouse ineligible for coverage.</li> </ul>
Your natural child, step-child, child placed for adoption or adopted child, or a child for whom you have legal guardianship	To age 26	<ul style="list-style-type: none"> <li>• Not applicable</li> </ul>
Your natural child, legally adopted child, or child for whom you have legal guardianship who is recognized as an alternate recipient under a <a href="#">Qualified Medical Child Support Order (QMCSO)</a> .	To age 26	<ul style="list-style-type: none"> <li>• If a court decree requires the primary covered participant to provide coverage</li> </ul>
Your overage disabled child	Age 26 or older	<ul style="list-style-type: none"> <li>• Unmarried</li> <li>• Permanently and totally disabled according to the medical claims administrator<sup>1</sup></li> <li>• Unable to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than one year according to the claims administrator</li> <li>• Who lives with you, in an institution or in a home that you provide</li> <li>• Who is financially dependent on you</li> </ul>

<sup>1</sup> If only enrolled in dental, permanently and totally disabled status will be determined by the dental claims administrator.



## *Class II Dependents*

No new Class II Dependents can be enrolled. Currently enrolled Class II Dependents (who are not eligible for Medicare) are eligible for coverage under the Sandia Total Health programs. Class II Dependents who are Medicare-primary are not eligible for coverage. Class II Dependents are not eligible to receive substance abuse benefits under the Sandia Total Health programs.

**Important:** If you disenroll your Class II Dependent, you cannot re-enroll them.

Your Class II Dependent must satisfy all of the following conditions to continue coverage:

- Is unmarried (unless they are your or your Spouse's parent, step-parent, or grandparent)
- Is financially dependent on you
- Has a total income, from all sources, of less than \$15,000 per calendar year other than the support you provide
- Has lived in your home, or one provided by you in the United States, for the most recent six months, and
- Is not eligible for Medicare

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

## **Eligibility for Tax-Free Health Coverage**

For purposes of coverage under the medical and dental plans, a dependent is eligible for **tax-free health coverage** under the Internal Revenue Code as follows:

- Your Spouse who is a federal tax dependent;
- Your children until the end of the year in which they turn age 26, regardless of whether they are married or live with you and regardless of whether you provide any support;
- Your mentally or physically disabled adult dependent children who live with you and who are primarily dependent on you for support;
- Any other person who meets the Internal Revenue Service (IRS) definition of a tax dependent (without regard to the income limit) which means an individual whose primary residence is your home, who is a member of your household, for whom you provide more than one-half of their support, and who is not the qualifying child of the employee or any other individual.
- An employee can treat another person's qualifying child as a qualifying relative if the child satisfies the other requirements listed here and if the other person isn't required to

file a tax return and either doesn't file a return or files one only to get a refund of withheld income taxes.

## Events Causing Your Dependent to Become Ineligible

If your dependents do not meet the dependent eligibility criteria as required by the Sandia medical or dental programs, they do not qualify for coverage and you must disenroll them. Coverage ends at the end of the month in which the dependent became ineligible.

The following events make your dependent(s) ineligible for coverage under a Sandia medical and/or dental Program and you must disenroll them within 31 calendar days following one or more of the following events:

If your dependent is:	Loss of eligibility occurs due to:
A Spouse	<ul style="list-style-type: none"> <li>• Divorce</li> <li>• Legal separation</li> <li>• Annulment</li> <li>• Death</li> </ul>
A Class I dependent child	<ul style="list-style-type: none"> <li>• Turning age 26</li> <li>• Dissolution of legal guardianship</li> <li>• No longer covered under a QMCSO</li> <li>• Death</li> </ul>
A Class I dependent stepchild	<ul style="list-style-type: none"> <li>• Turning age 26</li> <li>• No longer covered under a QMCSO</li> <li>• Death</li> </ul>
A Class I dependent over age disabled child	<ul style="list-style-type: none"> <li>• Marriage</li> <li>• Determination by Claims Administrator that the child is no longer eligible for disabled coverage</li> <li>• Child no longer lives with you or in an institution or home you provide</li> <li>• No longer financially dependent on you</li> <li>• No longer covered under a QMCSO</li> <li>• Death</li> </ul>
A Class II Dependent child, grandchild, brother, sister	<ul style="list-style-type: none"> <li>• Marriage</li> <li>• Has total income, from all sources, of \$15,000 or more per calendar year (other than the support you provide)</li> <li>• No longer financially dependent on you</li> <li>• No longer lives in your home or one provided by you (in the United States)</li> <li>• No longer covered under a QMCSO</li> <li>• Death</li> <li>• Becomes eligible for Medicare</li> </ul>
A Class II Dependent parent, step-parent, or grandparent	<ul style="list-style-type: none"> <li>• Has total income, from all sources, of \$15,000 or more per calendar year (other than the support you provide)</li> <li>• No longer financially dependent on you</li> <li>• No longer lives in your home or one provided by you (in the United States)</li> <li>• Death</li> <li>• Becomes eligible for Medicare</li> </ul>

## Failure to Disenroll

You must disenroll your ineligible dependent within 31 calendar days of the date that your dependent no longer meets the eligibility criteria for coverage under a Sandia medical or dental benefit. Refer to [Section 5: Enrollment/Disenrollment Events](#), for information on how to disenroll dependents.

If you do not disenroll your ineligible dependent, Sandia reserves the right to:

- Take action that results in permanent loss of coverage for you and your dependents for fraudulent use of the Sandia Health Plan for Retirees.
- Report the incident to the DOE Office of the Inspector General.
- Terminate any rights to temporary; continued coverage under COBRA (if Sandia is not notified within 60 calendar days of what would have been the loss of coverage through Sandia).
- Pursue legal or other administrative action to recover expenses/improper payments.

Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation subject to current law.

## Medicare-Eligible Members

If you or any of your dependents are age 65 or older or are eligible for Medicare as a result of disability, Medicare will be your primary medical coverage. In these instances, the applicable member (you or any of your dependents) must be covered by Medicare Part A and B in order to continue medical coverage through Sandia. Refer to [Section 9: Medicare and the NTESS Retiree Health Benefits Plan](#), for more information. **You are required to notify Via Benefits if you or your covered dependent becomes eligible for Medicare Primary Coverage.**

## Process for Aging into Medicare

If you are a Retiree or retiree dependent, approximately four months prior to when you or your dependent(s) turn 65, Via Benefits will send you a Medicare Welcome Kit. Via Benefits will call you to arrange a time when you are available to enroll in one of the Sandia-sponsored Medicare Advantage plans or the [Your Spending Arrangement \(YSA\) Program](#) (depending upon eligibility for the various options).

**IMPORTANT:** If a covered member who is eligible for Medicare Primary Coverage is provided coverage on a primary basis under this or any other Sandia medical Program, the Primary Covered Member will be responsible for reimbursing Sandia for any ineligible benefits.

## Provision for Covered Members with End-Stage Renal Disease

If Medicare is not your Primary Coverage, you may still be eligible for Medicare primary medical coverage due to End-Stage Renal Disease (ESRD). Sandia medical benefits may continue as your Primary Coverage for the first 33 months (from the time you start dialysis), which includes the 30-month coordination period with Medicare as your secondary coverage.

After the 30-month coordination period, Medicare will become your Primary Coverage. Sandia will pay benefits only as secondary payer for benefits provisions under a Sandia medical Program, regardless of whether you or your covered dependent enrolled in Medicare Parts A and B. You are required to notify Via Benefits if you or your covered dependent becomes eligible for Medicare Primary Coverage.

**IMPORTANT:** If a covered member who is eligible for Medicare Primary Coverage (generally someone with ESRD who has already received 33 months of Medicare coverage) is provided coverage on a primary basis under this or any other Sandia medical Program, the Primary Covered Member will be responsible for reimbursing Sandia for any ineligible benefits.

### **Qualified Medical Child Support Order (QMCSO)**

Generally, your Sandia health 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 any judgment, decree, or order (including a court-approved settlement agreement) that is issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law, which has the force and effect of law in that state; 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; and that Sandia has determined is qualified under the terms of ERISA and applicable state law. The Sandia Health Plan for Retirees will comply with the terms of a QMCSO. Federal law provides that a medical child support order must meet certain form and content requirements to be a QMCSO. Coverage under a Sandia medical and/or dental Program pursuant to a medical child support order will not become effective until Sandia determines that the order is a QMCSO. Sandia will review the medical child support order to determine whether it meets the criteria for a QMCSO. If you have questions about or wish to obtain a copy of the procedures governing a QMCSO Determination (at no charge), contact Sandia Labs Health Plans Team at 505-844-4237, option 2.

## Section 5. Enrollment/Disenrollment Events

This section outlines those events that allow enrollment into or disenrollment from the Sandia medical or dental Programs.

### When You Can Enroll

You can enroll yourself and/or your eligible dependents in your medical and/or dental Program:

- Upon retirement
- Upon becoming a Surviving Spouse (if currently a covered dependent under medical coverage)
- Upon termination of employment with Sandia as a Long-Term Disability Terminee
- During the annual open enrollment
- Upon an eligible mid-year election change event (see [Mid-Year Election Change Events Allowing Enrollment](#) section)
- If the enrollment of a dependent child does not affect your premium-share amount, you can enroll a dependent child at any time during the calendar year, with coverage effective on the date the enrollment form is received by Via Benefits. There will be no retroactive coverage.

### When You Can Disenroll

You can disenroll yourself and/or your eligible dependents in your medical and/or dental Program during the annual open enrollment or at any time during the year. However, to re-enroll them you must have an eligible mid-year election enrollment change event as outlined in the [Mid-Year Election Change Events Allowing Enrollment](#) section. **Coverage for any eligible dependent is based on your coverage as a Primary Covered Member; therefore, if you drop coverage for yourself, you are also dropping coverage for all of your dependents.**

**IMPORTANT:** If you are a Surviving Spouse and you disenroll yourself and/or your covered dependents, you will not be able to re-enroll yourself and/or your covered dependents. Refer to [Section 4: Eligibility Information](#), for information on the Surviving Spouse Medical Plan Option.

With respect to individual plans you have enrolled in under the Your Spending Arrangement (YSA) option, these plans are approved and managed by the Centers of Medicare and Medicaid (CMS). Outside of a Qualifying Event, plan changes may be made during the annual enrollment period for a January 1 effective date. Coverage may be dropped at any time. Refer to the [Your Spending Arrangement \(YSA\) Program Summary](#) for information on Qualifying Events.

**IMPORTANT:** If your covered dependent loses eligibility as outlined under [Section 4: Eligibility Information](#) and you do not disenroll that dependent within 31 calendar days, you are subject to certain consequences as outlined in [Failure to Disenroll](#).

## Enrolling Upon Retirement

Upon retirement, if you are not currently enrolled in a Sandia medical or dental Program, you can enroll within 31 calendar days, as long as you meet the eligibility criteria as outlined in [Section 4: Eligibility Information](#). The following information outlines what happens upon retirement if you are already enrolled in a medical and/or dental Program as an employee. Refer to the Retiree Medical Plan Option section for more information.

**You will remain covered under your active coverage until the end of the month in which you retire.**

### *PreMedicare Retiree Coverage*

If you are a PreMedicare Retiree and you do not waive coverage within the first 31 calendar days of retirement, the following will apply:

- If you are enrolled in the [Sandia Total Health Program \(administered by UnitedHealthcare\)](#), you will automatically be enrolled by Via Benefits in that Program.
- If you are enrolled in the [Sandia Total Health Program \(administered by Blue Cross Blue Shield of New Mexico\)](#), you will automatically be enrolled by Via Benefits in that Program.
- If you are enrolled in the [Sandia Total Health Program \(administered by Kaiser Permanente\)](#), you will automatically be enrolled by Via Benefits in that Program.
- If you are enrolled in the [Dental Care Program](#), you will automatically be enrolled by Via Benefits in the Dental Care Program.

Any enrolled PreMedicare dependents will be enrolled in the same Program that you are enrolled in. Any enrolled Medicare dependents will need to enroll in a Medicare plan with Via Benefits to continue coverage. Refer to the [Medicare Retiree Coverage](#) for information.

Under certain situations, you (and your covered dependents) may experience a *temporary* lapse in coverage. This may happen, for instance, when your retirement begins near the end of a month. Although carrier systems may not show as though you have coverage, when Via Benefits' and the carrier's records are synchronized (within 7-10 business days), you will have coverage retroactive to the first day of the month following retirement.

**Example:** For example, you officially retire on March 27 and are enrolled in Sandia Total Health STH UHC. You will keep your employee STH UHC coverage through March 31. Beginning April 1, as long as you have not made any changes to your coverage, you will begin your Retiree coverage of STH UHC. You will not be sent a new ID cards as you will continue to use your existing ones (UHC and Express Scripts). UHC and Express Scripts may not have you listed in the records on April 1; however after approximately 7-10 days you will be back in their system with a coverage effective date of April 1. If you see a doctor during the period when you are not on UHC's system, you will still be able to submit claims because of the coverage retroactive to the beginning of the month. If you need to pick up a prescription during this time period, you will need to contact Via Benefits at 888-598-7809.

You should receive a Welcome Packet from Via Benefits approximately 7-14 business days after your retirement has been processed and approved by Sandia. For changes in coverage, please contact Via Benefits.

**IMPORTANT:** To enroll in the YSA Program, upon becoming Medicare eligible, you must have Medicare Parts A and B prior to the first day following the month in which you retire. If you and/or your enrolled dependents do not have Medicare Parts A and B by this date, you will not be able to enroll in coverage until you have Medicare Parts A and B.

### ***Medicare Retiree Coverage***

If you are a Medicare Retiree and you want to continue medical coverage with Sandia, you will need to enroll with Via Benefits in individual Medicare plan(s) through the YSA Program prior to the end of the month in which you retire, for coverage effective the first of the following month. New coverage will become effective the first day of the following month of retirement.

Each enrolled Medicare individual can make an independent election; however, the retiree must elect coverage in order for any dependents to continue coverage through Sandia.

Any enrolled PreMedicare dependents will automatically be enrolled in the Program you were enrolled in as an active employee. For example, if you and your covered dependents were enrolled in the Sandia Total Health (administered by UHC), your PreMedicare dependents will be enrolled in that Program by Via Benefits.

Within 2-3 weeks from the day your retirement has been input by your Human Resources Business Professional (HRBP), you and/or any covered Medicare-eligible dependents will need to call Via Benefits to discuss options for your Retiree medical coverage. View the ViaBenefits program information in either the [Benefit Guide for Individuals who Retired Prior to 1/1/2012](#) or the [Benefit Guide for Individuals who Retired After 1/1/2012](#) by going to [hr.sandia.gov](http://hr.sandia.gov).

**IMPORTANT:** In order to enroll in the YSA Program, you and your Medicare-eligible dependents must have Medicare Parts A and B prior to the first day following the month in which you retire. If you and/or your enrolled dependents do not have Medicare Parts A and B by this date, you will be dropped from coverage.

### **Waiver of Coverage**

Upon becoming a new Retiree or Long-Term Disability Terminee, you have the option to waive coverage for yourself and your dependents. Coverage for any eligible dependent is based on your coverage as a Retiree or Long-Term Disability Terminee; therefore, if you waive coverage for yourself, you are also waiving coverage for all of your dependents. Generally, if you waive coverage, the next opportunity for you to reinstate your coverage under a Sandia medical (or dental Program for Retirees) will be during the annual Open Enrollment period Sandia holds each fall, with coverage becoming effective January 1 of the following year, or upon an eligible mid-year election change event.

## **Enrolling Upon Becoming a Surviving Spouse/Dependent**

### ***Surviving Spouse of an Employee***

If you are a covered Surviving Spouse of a regular employee, Sandia will notify Via Benefits of the employee's death. Via Benefits will contact you, either by phone or letter, regarding your options through the Surviving Spouse Medical Plan option. In the event you do not receive notification from Via Benefits, it is your (or an authorized representative's) responsibility to contact them in order to get enrolled into the Surviving Spouse Medical Plan option within the applicable time frame. You have 31 calendar days from the date of death of the Retiree/employee to enroll in the Surviving Spouse Medical Plan. Via Benefits will enroll you in the applicable medical Program, invoice you and collect any required premiums, and notify the applicable vendors of your eligibility. Refer to [Surviving Spouse Medical Plan Option](#) for more information.

If you elect the Surviving Spouse Medical Plan, you are waiving your rights to continuing your medical coverage under COBRA.

Sandia will also notify COBRA Administrator of the employee's death. If you were covered under the Dental Care Plan and/or Vision Care Plan, UHCBS will notify you of the option to continue these coverages under COBRA as you are not eligible as a Surviving Spouse. Refer to Coverage through COBRA for information.

Alternatively, you can elect COBRA coverage for your medical coverage. If you would like to do this, you would elect the COBRA coverage through UHCBS, thus opting out of the Surviving Spouse Medical Plan.

Upon the death of the Surviving Spouse, if you elected the Surviving Spouse Medical Plan option, any enrolled dependents will lose coverage. COBRA coverage is not available. If the Surviving Spouse elected COBRA coverage for medical, any enrolled dependents may have rights to continued COBRA coverage. Refer to Coverage through COBRA for more information.

**IMPORTANT:** Coverage under the active employee plan will continue until the end of the month in which the employee deceases. If you are the Surviving Spouse of an employee and you are Medicare Eligible, you must enroll in Medicare Parts A and B in order to continue coverage through Sandia. If you or your enrolled dependents (if applicable) do not have Medicare Parts A and B by the beginning of the following month in which the employee deceased, you will be dropped from coverage.

### ***Surviving Spouse of a Retiree***

If you are a covered Surviving Spouse of an eligible Retiree, you (or an authorized representative) must notify Via Benefits within 31 calendar days of the Retiree's death. Via Benefits will enroll you in the applicable medical Program, invoice you and collect any required premiums, and notify the applicable vendors of your eligibility. Refer to [Surviving Spouse Medical Plan Option](#) for more information.

If you elect the Surviving Spouse Medical Plan, you are waiving your rights to continuing your medical coverage under COBRA. If you were covered under the Dental Care Plan, Via Benefits



will notify COBRA Administrator who will in turn notify you of the option to continue dental coverage under COBRA as you are not eligible as a Surviving Spouse. Refer to Coverage through COBRA for more information on COBRA.

Via Benefits is also required to notify you of your medical coverage. Alternatively, you can elect COBRA coverage for your medical coverage. If you would like to do this, you would elect the COBRA coverage through UHCBS, thus opting out of the Surviving Spouse Medical Plan.

Upon the death of the Surviving Spouse, if you elected the Surviving Spouse Medical Plan option, any enrolled dependents will lose coverage. COBRA coverage is not available. If the Surviving Spouse elected COBRA coverage for medical, any enrolled dependents may have rights to continued COBRA coverage. Refer to Coverage through COBRA for more information.

**Important:** Coverage under the Retiree plan will continue until the end of the month in which the Retiree deceased.

### **Enrolling Upon Becoming a Surviving Dependent (Other than Spouse)**

The Surviving Dependent (other than a Surviving Spouse) may continue medical, dental, and/or vision coverage (whichever is applicable) for up to 36 months if they meet the eligibility criteria as outlined in [Section 4: Eligibility Information](#), and the election to continue is made by the election date referenced in the continuation of coverage notification sent by UnitedHealthcare Benefit Services (UHCBS). UHCBS is responsible for notification of the option to continue coverage through Sandia, the collection of premiums, and notification of eligibility to the applicable vendors. Refer to [Surviving Spouse Medical Plan Option](#) for more information.

**IMPORTANT:** Coverage under the active employee/Retiree plan will continue until the end of the month in which the employee/Retiree deceased. If you are the dependent of an employee and you are Medicare Eligible, you must enroll in Medicare Parts A and B in order to continue coverage through Sandia. If you do not have Medicare Parts A and B by the beginning of the following month in which the employee deceased, you will be dropped from coverage.

### **Enrolling Upon Becoming a Long-Term Disability Terminee**

Upon terminating from Sandia and becoming eligible under the Long-Term Disability Terminee Medical Plan Option, if you are not currently enrolled in a Sandia medical Program, you can enroll within 31 calendar days, as long as you meet the eligibility criteria as outlined in [Section 4: Eligibility Information](#). The following information outlines what happens upon terminating from Sandia as a Long-Term Disability Terminee if you are already enrolled in a medical Program as an employee. Refer to [Long-Term Disability Terminee Medical Plan Option](#) for more information.

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. If you are under 65 and not Medicare Eligible upon termination from Sandia, you will remain in the medical Program you are currently enrolled in (but at the Retiree level of coverage). Sandia will contact Via Benefits on your behalf. Via Benefits is responsible for enrolling you in the applicable medical Program, the collection of premiums, and notification of eligibility to the applicable vendors.

**IMPORTANT:** Coverage under the active employee plan will continue until the end of the month in which you terminate. If you are Medicare Eligible, you must enroll in Medicare Parts A and B to continue coverage through Sandia. If you or your enrolled dependents (if applicable) do not have Medicare Parts A and B by the beginning of the following month, you will be dropped from coverage.

## **Enrolling/Disenrolling During Annual Open Enrollment**

Every year in the fall you have the option to change your medical and/or dental coverage, waive coverage, enroll in coverage, and/or add or drop dependents. Open Enrollment is done through the telephone with Via Benefits via a toll-free number. Elections made during Open Enrollment take effect January 1 of the following calendar year. **If you do not make any changes during Open Enrollment, your current elections for medical or dental will carry into the next calendar year.**

**IMPORTANT:** If you are eligible for Medicare and elect coverage under the UnitedHealthcare Group Medicare Advantage PPO Plan, Humana Medicare Employer HMO Plan, the Kaiser Senior Advantage Plan, or the YSA option, you must be covered under both Medicare Part A and B. If you elect to delay enrollment in Medicare Part B, if you choose to enroll at a later date you may be subject to a Medicare penalty. Refer to [Section 9: Medicare and the Sandia Retiree Health Benefits Plan](#).

## **Mid-Year Election Change Events Allowing Enrollment**

Generally, once you make an election, you cannot make a change until the next Open Enrollment period. However, certain events may allow mid-year enrollments into the medical and/or dental Programs. These events are called mid-year election change events and fall into the following categories:

- Change in status events (see below for consistency rule)
- Certain judgments, decrees or orders
- Entitlement to Medicare or Medicaid
- Change in cost
- Change in coverage

**Note:** Mid-year election change events, except for moving into or out of the Service Area or becoming Medicare Eligible, generally **DO NOT ALLOW** you to change from one medical Program to another. These are typically only allowed during the annual Open Enrollment period held each fall.

### ***Certain restrictions apply to the Your Spending Arrangement (YSA) Program***

A mid-year election enrollment change is permitted as long as the change in enrollment status event meets consistency requirements. A change in status event for enrollment must meet the consistency requirement according to the two rules as follows:

- The change in status event must affect eligibility for coverage under the Sandia Health Plan for Retirees or under a plan sponsored by the employer of your Spouse or dependent. Eligibility for coverage is affected if you become eligible or ineligible for coverage or if the event results in an increase or decrease in the number of your dependents who may benefit from coverage under the Sandia Health Plan for Retirees, and
- The election change must correspond with the change in status event.

Examples of the consistency requirement:

*A Retiree gets married and wants to enroll his new wife into his medical and dental. This is allowable due to the gain in eligibility.*

**IMPORTANT:** You must notify Via Benefits by telephone at 888-598-7809 for all enrollments and disenrollments. Via Benefits must be notified within 31 calendar days of the eligible mid-year election change event. You can also call Via Benefits to enroll a dependent after the 31<sup>st</sup> calendar day but before the 61<sup>st</sup> calendar day of the event for a birth, an adoption, or a placement for adoption, however, the coverage effective date will not be retroactive. Documentation supporting the request must be submitted to Via Benefits within 60 calendar days of the event (except where otherwise noted). If you notified Via Benefits of the enrollment request within the applicable time frame but no supporting documentation is received, no enrollment will be done. If you miss the enrollment period, the next opportunity to enroll will be during the Open Enrollment period each fall, with coverage effective January 1 of the following calendar year.

The following table outlines the eligible mid-year election change events allowing mid-year enrollment in the medical or dental Programs.

The table includes the allowable change, the documentation needed to support the change, and when coverage begins or ends (whichever is applicable):

Mid-Year Election Change Event	Allowable Change <sup>1</sup>	Supporting Documentation <sup>2</sup>	When Coverage Begins/ Ends <sup>3</sup>
<b>Change in Marital Status</b>			
Marriage	You may enroll yourself, Spouse, and any eligible dependent(s)	None	Coverage begins on the later of the date of the event creating eligibility or the date Via Benefits is notified.
Divorce, legal separation, annulment Note: You must submit the first page of the divorce decree, legal separation papers, or annulment papers	You may enroll yourself and any eligible dependents who lose coverage	You must submit a letter or notice from previous medical insurance carrier	Coverage begins on the later of the date of the event creating eligibility, date of loss of coverage or the date Via Benefits is notified.

<b>Mid-Year Election Change Event</b>	<b>Allowable Change<sup>1</sup></b>	<b>Supporting Documentation<sup>2</sup></b>	<b>When Coverage Begins/ Ends<sup>3</sup></b>
Death of Spouse	You may enroll yourself and any eligible dependent(s) who lose coverage	You must submit a letter or notice from previous medical insurance carrier	Coverage begins on the later of the date of the event creating eligibility, the date of loss of coverage, or the date Via Benefits is notified.
<b>Change in the Number of Dependents</b>			
Birth	You may enroll yourself, Spouse, newborn, and any eligible dependents. *** This does not apply to third generation dependents such as grandchildren.	None	Retroactive coverage to the date of the birth if enrolled within 31 calendar days of the birth. You can also enroll after 31 calendar days but before the 61 <sup>st</sup> calendar day from the date of birth, however, coverage will be effective on the date Via Benefits is notified. Please Note: Newborns are covered for the first 31 days of life automatically.
Adoption or placement for adoption <sup>(2)</sup>	You may enroll yourself, Spouse, newly adopted eligible children, and any other eligible dependent(s)	You must submit the official placement agreement and/or official adoption papers upon enrollment	Retroactive coverage to the date of the adoption or placement for adoption if enrolled within 31 calendar days of the adoption. You can also enroll after 31 calendar days but before the 61 <sup>st</sup> calendar day from the date of adoption or placement for adoption, however, coverage will be effective on the date Via Benefits is notified.
Legal Guardianship	You may enroll yourself, Spouse, newly eligible children, and any other eligible dependent(s)	You must submit the legal guardianship court papers granting permanent custody upon enrollment	Coverage begins on the later of the date of the event creating eligibility or the date Via Benefits is notified.
<b>Change in Dependent Status</b>			
Event by which dependent(s) satisfy eligibility requirements	You may enroll newly eligible dependents(s)	None (with the exception of disabled child – refer to <a href="#">Section 4: Eligibility Information</a> )	Coverage begins on the later of the date of the event creating eligibility or the date Via Benefits is notified.

<b>Mid-Year Election Change Event</b>	<b>Allowable Change<sup>1</sup></b>	<b>Supporting Documentation<sup>2</sup></b>	<b>When Coverage Begins/ Ends<sup>3</sup></b>
<b>Change in Employment Status of Spouse or Dependent that Affects Eligibility</b>			
Spouse or eligible dependent(s) terminates employment or retires	You may enroll yourself, Spouse or eligible dependent(s) who lose coverage	You must submit a letter or notice from previous medical insurance carrier	Coverage begins on the later of the date of the event creating eligibility, the date of loss of coverage or the date Via Benefits is notified.
Spouse, or eligible dependent(s) goes on strike or lockout	You may enroll yourself, Spouse, or dependent(s) who lose coverage	You must submit a letter or notice from previous medical insurance carrier	Coverage begins on the later of the event creating eligibility, the date of the loss of coverage or the date Via Benefits is notified.
Spouse or eligible dependent(s) commences an unpaid leave of absence	You may enroll yourself, Spouse or dependent(s) who lose coverage	You must submit a letter or notice from previous medical insurance carrier	Coverage begins on the later of the date of the event creating eligibility, the date of the loss of coverage or the date Via Benefits is notified.
Spouse or eligible dependent(s) have a change in work hours that makes them lose coverage	You may enroll yourself, Spouse or eligible dependent(s) who lose coverage	You must submit a letter or notice from previous medical insurance carrier	Coverage begins on the later of the date of the event creating eligibility, the date of loss of coverage or the date Via Benefits is notified.
Spouse or eligible dependent has a change in work site that makes them lose coverage	You may enroll yourself, Spouse, or dependent(s) who lose coverage	You must submit a letter or notice from previous medical insurance carrier	Coverage begins on the later of the event creating eligibility, the date of the loss of coverage or the date Via Benefits is notified.
<b>Change in Residence<sup>4 5</sup></b>			
Spouse and any eligible dependent(s) who move outside of their medical plan Service Area	You may enroll yourself, your Spouse and any eligible dependent(s) who lose coverage if move outside of a Service Area	You must submit a letter or notice from previous medical insurance carrier	Coverage begins on the later of the event creating eligibility, the date of the loss of coverage or the date Via Benefits is notified.
<b>Certain Judgments, Decrees or Orders</b>			
Judgment, decree or order which resulted from a divorce, legal separation, annulment, or change in legal custody, and must meet the requirements of a QMCSO	You may enroll the eligible dependent(s) consistent with the judgment, decree, or order	You must submit the official judgment, decree or order upon enrollment	Coverage begins on the later of the event creating eligibility, the date of the loss of coverage or the date Via Benefits is notified.

<b>Mid-Year Election Change Event</b>	<b>Allowable Change<sup>1</sup></b>	<b>Supporting Documentation<sup>2</sup></b>	<b>When Coverage Begins/ Ends<sup>3</sup></b>
<b>Change in Medicare Or Medicaid Entitlement</b>			
Retiree, Spouse, and/or eligible dependent(s) loses Medicare or Medicaid eligibility (other than coverage for pediatric vaccines only)	You may enroll yourself, Spouse, and any eligible dependent(s) who lose coverage	You must submit documentation from Medicare or Medicaid of loss of eligibility	Coverage begins on the later of the event creating eligibility, the date of the loss of coverage or the date Via Benefits is notified.
<b>Change in Cost</b>			
Sandia significantly decreases the cost of a medical Program (as determined by Sandia)	You may elect the medical Program with the significant decrease in cost for you and your enrolled dependent(s)	None	Coverage begins on the date Via Benefits is notified.
Sandia significantly increases the cost of a medical Program (as determined by Sandia)	You may waive coverage altogether or select another medical Program	None	Coverage begins on the date Via Benefits is notified.
<b>Change in Coverage</b>			
Retiree, Spouse, or eligible dependent(s) disenroll from an employer group plan during the open enrollment period that operates on a plan year other than a calendar year	You may enroll yourself, Spouse, or eligible dependent(s) who lose coverage	You must submit a letter or notice from previous medical insurance carrier	Coverage begins on the later of the event creating eligibility, the date of the loss of coverage or the date Via Benefits is notified.
Spouse or eligible dependent(s)' employer eliminates a medical plan during the year	You may enroll yourself, Spouse, and eligible dependent(s) who lose coverage	You must submit a letter or notice from previous medical insurance carrier	Coverage begins on the date Via Benefits is notified.
Sandia eliminates or significantly reduces (as determined by Sandia) benefits under one of the medical Programs that covers you in the middle of the Plan year	You may elect a different medical Program for you and your enrolled dependent(s)	None	Coverage begins on the date Via Benefits is notified.

<b>Mid-Year Election Change Event</b>	<b>Allowable Change<sup>1</sup></b>	<b>Supporting Documentation<sup>2</sup></b>	<b>When Coverage Begins/ Ends<sup>3</sup></b>
Sandia adds a new medical Program or coverage under an existing medical Program is improved significantly (as determined by Sandia) during the Plan year	You may elect the new medical Program or the improved medical Program for you and your enrolled dependent(s)	None	Coverage begins on the date Via Benefits is notified.
<p><sup>1</sup> If you are both Sandia employees, please note that if one of you loses eligibility due to an event, that event may qualify as a mid-year enrollment event for the person who lost eligibility. Any permitted change is subject to the No Duplicate Coverage provisions on page 14.</p> <p><sup>2</sup> Refer to Proof of Dependent Status in Section 3, Eligibility Information.</p> <p><sup>3</sup> With respect to individual and group-sponsored Medicare plans, coverage will be effect on the first day of the month following receipt of your enrollment information to the carrier(s) from Via Benefits.</p> <p><sup>4</sup> If you move outside a Kaiser Service Area under the Sandia Total Health, you can disenroll from Kaiser and enroll in another medical plan. Moving outside of a Medicare Advantage Service Area also allows you to disenroll from your plan and enroll in another plan.</p> <p><sup>5</sup> If you move within a Kaiser Service Area under the Sandia Total Health, you can disenroll from your medical plan and enroll in Kaiser. Moving within a Medicare Advantage Service Area also allows you to disenroll from your plan and enroll in another plan.</p>			

## Section 6. Program Premiums

This section outlines how premiums are charged according to the various classifications of members who are eligible for coverage under the medical and dental Programs.

For PreMedicare participants, the projected costs and contributions are reviewed each year and are subject to change. Plan costs and contributions are generally determined each January 1.

For Medicare participants, the Centers of Medicare and Medicaid (CMS) regulate the premiums for Medicare products, including the Sandia-sponsored Medicare Advantage plans. As such, they dictate when plans can release their premiums to the public.

The premiums for coverage under the medical and dental Programs are provided during the open enrollment period Via Benefits will hold each fall prior to the start of the plan year. You can contact Via Benefits at 888-598-7809 for premium-share information for coverage.

**Note:** If there is an insignificant (as determined by Sandia) cost increase or decrease for a medical or dental Program during the year, and it requires a corresponding change in your premium-share amount, Sandia will automatically increase or decrease your contributions on a prospective basis to reflect the change.

### Retiree Premium

You will remain in your employee medical and dental Program at the applicable employee premium-share for the duration of the month in which you retire. If you are PreMedicare and/or your covered dependents are PreMedicare, upon the first day of the following month, Via Benefits will enroll you and your covered dependents (if applicable) in the medical and dental Program you had as an active. If you are Medicare Eligible and/or your covered dependents are Medicare Eligible, you and/or your covered dependents will need to actively make an election with Via Benefits to continue your coverage through Sandia. Refer to [Section 4: Eligibility Information](#) and [Section 5: Enrollment/Disenrollment Events](#) for more information.

Beginning with the month in which you are covered by a Retiree medical and/or dental Program, you will receive billing information from Via Benefits regarding your applicable Retiree premium-share amount or YSA credit (if applicable).

### *Medical Premiums*

#### PreMedicare Retirees

There are five different PreMedicare retiree premium-share arrangements as outlined on the following pages that would apply to you. These arrangements are typically based on when you hired or rehired into Sandia and when you retired from Sandia.

**Premium-share arrangement #1:** Sandia pays the full amount of coverage for you and your covered dependents during retirement if you retired 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
- Before January 1, 1988, with at least 15 years of service
- Between January 1, 1988, and December 31, 1994, with a service or disability pension

**Premium-share arrangement #2:** Employees who retired with a service or disability pension after December 31, 1994, and before January 1, 2003, will pay 10 percent of the full experience-rated premium.

**Premium-share arrangement #3:** The following table outlines the percentage a Retiree will pay of the full experience-rated premium based on his/her term of employment if he/she retired after December 31, 2002, but prior to January 1, 2012:

Term of Employment	Premium Share %
30+ years	10%
25-29 years	15%
20-24 years	25%
15-19 years	35%
10-14 years	45%

**Premium-share arrangement #4:** Employees who retired with a service pension, on or after January 1, 2012 and were:

- a non-represented employee hired or Rehired prior to January 1, 2009
- an OPEIU-represented employee hired or Rehired prior to July 1, 2009 or
- an MTC- or SPA-represented employee hired or Rehired prior to July 1, 2010

are eligible to receive a monthly contribution (also known as a subsidy) that Sandia will pay toward your Sandia-sponsored group medical and/or dental coverage as follows (based on his/her term of employment):

Term of Employment	Monthly Subsidy (Retiree only)	Monthly Subsidy (Retiree plus one dependent)	Monthly Subsidy (Retiree plus two or more dependents)*
30+ years	\$700	\$1,400	\$2,100
25-29 years	\$661	\$1,322	\$1,983
20-24 years	\$583	\$1,166	\$1,749
15-19 years	\$506	\$1,012	\$1,518
10-14 years	\$428	\$856	\$1,284

\* Family subsidy/contributions are capped at three times the retiree only amount.

The subsidy will **NOT** increase year over year. As healthcare premiums rise, these retirees will pay the difference between the premiums and the subsidy.

**Example:** If you, as a single Retiree with 30 years of employment, retire on February 1, 2016, and you elect both medical and dental coverage through Sandia, you will receive \$700 towards your medical and dental coverage. If the monthly medical and dental premium increased from \$740 in 2017 to \$962, your premium-share for medical only would go from \$40 to \$262 (\$962 minus \$700). You pay the full dental premium on top of this amount.

**Example:** If you, as a Retiree, retire on or after February 1, 2016, and waive medical coverage but elect dental coverage only through Sandia, the subsidy will cover the entire premium of \$45, so you would not have a premium share to pay.

**Premium-share arrangement #5:** Employees who retired on or after January 1, 2012 and were:

- a non-represented employee upon retirement and were hired or Rehired on or after January 1, 2009 and you meet the age and service requirements then in effect under the RIP or SIP for service eligibility
- an OPEIU-represented employee upon retirement and were hired or Rehired on or after July 1, 2009 and you meet the age and service requirements then in effect under the PSP for service eligibility
- an MTC- or SPA-represented employee upon retirement and were hired or Rehired on or after July 1, 2010 and you meet the age and service requirements then in effect under the PSP for service eligibility

...will pay 100% of the full experience-rated premium for medical coverage. Upon reaching Medicare eligibility, you and/or your covered dependents are no longer eligible for coverage through Sandia for medical. However, you can elect to use Via Benefits to assist you and/or your covered dependents with finding coverage in the marketplace.

**Example:** If you, as the Retiree, become eligible for Medicare on July 1, you will be dropped from your PreMedicare medical coverage effective July 1. If you have a covered Spouse who is not eligible for Medicare, he or she can continue in his/her applicable PreMedicare medical program.

## **Medicare Retirees**

**Premium-share arrangement #1:** Sandia pays the full amount of coverage (for Sandia-sponsored Medicare Advantage plans) or provides you with 100% of the YSA credit (as outlined in each year's [Benefit Guide for Individuals who Retired Prior to 1/1/2012](#)) for you and your covered dependents during retirement if you retired 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
- Before January 1, 1988, with at least 15 years of service
- Between January 1, 1988, and December 31, 1994, with a service or disability pension

**Premium-share arrangement #2:** Employees who retired with a service or disability pension after December 31, 1994, and before January 1, 2003, will pay 10 percent of the full premium (for Sandia-sponsored Medicare Advantage plans) or Sandia will provide you with 90% of the YSA credit (as outlined in each year's [Benefit Guide for Individuals who Retired Prior to 1/1/2012](#)).

**Premium-share arrangement #3:** The following table outlines the percentage a Retiree, with a service or disability pension, will pay of the full premium (for Sandia-sponsored Medicare Advantage plans), based on his/her term of employment if he/she retired after December 31, 2002, but prior to January 1, 2012:

Term of Employment	Premium Share %
30+ years	10%
25-29 years	15%
20-24 years	25%
15-19 years	35%
10-14 years	45%

Alternatively, a Retiree may elect the YSA and will be eligible to receive a percentage of the full YSA credit based on his/her term of employment (as outlined in each year's [Benefit Guide for Individuals who Retired Prior to 1/1/2012](#)). Refer to the [Your Spending Arrangement \(YSA\) Program Summary](#) for more information.

**Premium-share arrangement #4:** Employees who retired with a service pension, on or after January 1, 2012 and were:

- a non-represented employee hired or Rehired prior to January 1, 2009
- an OPEIU-represented employee hired or Rehired prior to July 1, 2009 or
- an MTC- or SPA-represented employee hired or Rehired prior to July 1, 2010

...are eligible to receive a monthly contribution (also known as YSA credits) that Sandia will pay towards individual Medicare plans and/or Sandia-sponsored dental coverage. Refer to the [Your Spending Arrangement \(YSA\) Program Summary](#) for more information. A retiree is eligible for a percentage of the full YSA credit (as outlined in each year's [Benefit Guide for Individuals who Retired After 1/1/2012](#)) based on his/her term of employment. YSA credits will increase annually by 50% of the healthcare component of the Consumer Price Index.

**Premium-share arrangement #5:** Employees who retired on or after January 1, 2012 and were:

- a non-represented employee upon retirement and were hired or Rehired on or after January 1, 2009 and you meet the age and service requirements then in effect under the RIP or SIP for service eligibility
- an OPEIU-represented employee upon retirement and were hired or Rehired on or after July 1, 2009 and you meet the age and service requirements then in effect under the PSP for service eligibility

- an MTC- or SPA-represented employee upon retirement and were hired or Rehired on or after July 1, 2010 and you meet the age and service requirements then in effect under the PSP for service eligibility

Are not eligible for medical coverage. However, you can elect to use Via Benefits to assist you and/or your covered dependents with finding coverage in the marketplace.

**Example:** If you, as the Retiree, become eligible for Medicare on July 1, you will be dropped from your PreMedicare medical coverage effective July 1 and will not be eligible for any medical coverage through Sandia. If you have a covered Spouse who is not eligible for Medicare, he or she can continue in his/her applicable PreMedicare medical program.

### *Dental Premiums*

Employees who retired prior to January 1, 2009 do not pay a premium share for the Sandia-sponsored [Dental Care Program](#).

Employees who were hired or rehired prior to January 1, 2009 and retired on or after January 1, 2009, but prior to January 1, 2012 pay a monthly premium of 20% of the full experience-rated premium. Rates are based on retiree, retiree plus one, or retiree plus two or more eligible dependents.

Non-represented employees who were hired or rehired prior to January 1, 2009, OPEIU-represented employees who were hired or Rehired prior to July 1, 2009, and MTC- or SPA-represented employees who were hired or Rehired prior to July 1, 2010, and who retired on or after January 1, 2012, will pay the full experience-rated premium. Rates are based on retiree, retiree plus one, or retiree plus two or more eligible dependents. Refer to [Medical Premiums](#), [PreMedicare Retirees](#) and [Medicare Retirees](#) in this section for information on how you may be eligible to receive payment from Sandia to cover all or part of your dental premiums.

If you were a non-represented employee upon retirement and were hired or rehired on or after January 1, 2009, and you meet the age and service requirements then in effect under the RIP for service eligibility, you will pay 100% of the full experience-rated premium (as long as you are not eligible for Medicare). Once you, the Retiree, becomes Medicare Eligible, you AND any covered dependents will be disenrolled from Sandia's dental coverage at the end of the month prior to the month in which the Retiree becomes Medicare Eligible.

If you were an OPEIU-represented employee upon retirement and were hired or rehired on or after July 1, 2009, and you meet the age and service requirements then in effect under the PSP for service eligibility, you will pay 100% of the full experience-rated premium (as long as you are not eligible for Medicare). Once you, the Retiree, becomes Medicare Eligible, you AND any covered dependents will be disenrolled from Sandia's dental coverage at the end of the month prior to the month in which the Retiree becomes Medicare Eligible.

If you were an MTC- or SPA-represented employee upon retirement and were hired or rehired on or after July 1, 2010, and you meet the age and service requirements then in effect under the PSP for service eligibility, you will pay 100% of the full experience-rated premium (as long as you are not eligible for Medicare). Once you, the Retiree, becomes Medicare Eligible, you AND

any covered dependents will be disenrolled from Sandia's dental coverage at the end of the month prior to the month in which the Retiree becomes Medicare Eligible.

## Dual Sandians

If you are a Sandia Retiree married to another Sandia employee or to a Sandia Retiree, you are considered a Dual Sandian. You, as a Dual Sandian, may elect to cover yourself as (1) an individual, or (2) a dependent of your Sandia active or Retiree Spouse, or (3) as the primary covered Retiree with your Sandia Spouse as a dependent. If you, as the Retiree, are the Primary Covered Member, cost-sharing of monthly premiums will depend upon when you retired.

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). Dependents may NOT be covered under both Sandians simultaneously.

**Note:** Under Sandia's medical or dental programs, 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.

Retirees, or other qualifying individuals who are covered by any Sandia medical or dental Program are not eligible to participate in a second Sandia medical or dental Program (i.e., no double coverage by Sandia health Programs). You have the option to change your Sandia health benefit coverage once a year during the open enrollment period Via Benefits holds each fall.

**IMPORTANT:** If your Spouse is an active on-roll employee and you take his/her coverage when you retire instead of your Retiree coverage, you will be eligible, as a Retiree, to receive the premium share arrangements that were in effect when you retired. For instance, if you retired in 2011 and are a dependent under your active employee Spouse's coverage, regardless of when your Spouse retires, you, as a Retiree, will be eligible for the premium share arrangement that was in effect when you retired in 2011. For information regarding pension payments and Retiree medical, please see [Section 4: Eligibility Information](#).

## Surviving Spouse

In order to determine whether you are eligible to continue coverage under the Surviving Spouse Medical Plan, refer to [Section 4: Eligibility Information](#), for more information on the Surviving Spouse Medical Plan Option.

If you are an eligible Surviving Spouse under the Surviving Spouse Medical Plan Option, you may be eligible to continue coverage by paying the monthly premium, which is a percentage of the full experience-rated premium (for PreMedicare survivors), or a percentage of the Sandia-sponsored Medicare Advantage plan insured premium (for Medicare survivors). You may also be eligible for a percentage of the YSA credits.

## **Surviving Spouse of Active Regular Employee**

### **If you are a Surviving Spouse of:**

- an on-roll regular non-represented employee who hired or Rehired in prior to January 1, 2009
- an on-roll regular OPEIU-represented employee who hired or Rehired in prior to July 1, 2009
- an on-roll regular MTC- or SPA-represented employee who hired or Rehired in prior to July 1, 2010

### **AND**

- you are a survivor of a regular employee with less than 15 years term of employment who dies while covered under one of the medical Programs,

You will pay 100% of the full experience-rated premium (for PreMedicare) or of the Sandia-sponsored Medicare Advantage plans (for Medicare). You are not eligible for the YSA Program.

### **If you are a Surviving Spouse of:**

- an on-roll regular non-represented employee who hired or Rehired in prior to January 1, 2009
- an on-roll regular OPEIU-represented employee who hired or Rehired in prior to July 1, 2009
- an on-roll regular MTC- or SPA-represented employee who hired or Rehired in prior to July 1, 2010

### **AND**

- you are a survivor of a regular employee with 15 years or more term of employment (dependent upon the employee's hire date) who dies while covered under one of the medical Programs,

you will pay 50% of the full experience-rated premium (for PreMedicare) or of the Sandia-sponsored Medicare Advantage Plans (for Medicare). If you elect the YSA Program, you will receive 50% of the full YSA credit.

### **If you are a Surviving Spouse of:**

- a non-represented employee who hired or Rehired in on or after January 1, 2009
- an OPEIU-represented employee who hired or Rehired in on or after July 1, 2009
- an MTC or SPA-represented employee who hired or Rehired in on or after July 1, 2010

...who dies while covered under one of the medical Programs, you (and any enrolled dependents) are eligible to continue ONLY PreMedicare medical coverage through Sandia through the Surviving Spouse Medical Plan Option. Upon becoming Medicare Eligible, coverage

for the Surviving Spouse and any enrolled Medicare dependents will be discontinued. If your dependent(s) are PreMedicare, they will have access to Sandia-sponsored medical coverage by paying 100% of the cost. If any of your dependents become Medicare Eligible prior to you, as the Surviving Spouse, they will not have access to medical coverage through Sandia. However, you and/or your eligible dependents will be able to utilize Via Benefits to assist you in purchasing individual Medicare plans and/or dental coverage.

The Surviving Dependent children with no surviving parent may continue medical coverage up to 36 months of coverage by paying the COBRA rate for medical coverage.

**Note:** If applicable, dental and vision coverage will be offered under the COBRA provisions as outlined in [Section 12: Continuation of Group Health Coverage](#).

### Surviving Spouse of Retiree

If you are a Surviving Spouse of an employee who retired on or before December 31, 2011, you will pay 50% of the full experience-rated premium (for PreMedicare) or of the Sandia-sponsored Medicare Advantage Plans (for Medicare). If you elect the YSA Program, you will receive 50% of the full YSA credit.

If you are a Surviving Spouse of:

- an on-roll regular non-represented employee who hired or Rehired in prior to January 1, 2009
- an on-roll regular OPEIU-represented employee who hired or Rehired in prior to July 1, 2009
- an on-roll regular MTC- or SPA-represented employee who hired or Rehired in prior to July 1, 2010

**AND**

- the employee retired after December 31, 2011

For PreMedicare Surviving Spouses (and any enrolled PreMedicare dependents), Sandia will contribute a monthly subsidy toward your Sandia-sponsored group PreMedicare medical coverage as noted in the table on the following page. The subsidy will not increase year over year. As healthcare premiums rise, surviving spouses will pay the difference between the full experience-rated premium and the subsidy. For Medicare Surviving Spouses (and any enrolled Medicare dependents), Sandia will provide you with YSA credits to use to purchase individual Medicare plans and/or individual dental plans through Via Benefits. For premium information, refer to the [Benefit Guide for Individuals who Retired Prior to 1/1/2012](#) or the [Benefit Guide for Individuals who Retired After 1/1/2012](#).

Coverage	PreMedicare Monthly Subsidy
Survivor-only coverage	\$370
Survivor plus one dependent coverage	\$740
Survivor plus two or more dependents	\$1,110
<b>Note:</b> Family contributions are capped at three times the applicable rate.	

If you are a Surviving Spouse of:

- a non-represented employee who hired or Rehired in on or after January 1, 2009
- an OPEIU-represented employee who hired or Rehired in on or after July 1, 2009
- an MTC or SPA-represented employee who hired or Rehired in on or after July 1, 2010

**AND**

- the employee retired after December 31, 2011

You (and any enrolled dependents) are eligible to continue ONLY PreMedicare medical coverage through Sandia by paying 100% of the full experience-rated premium.

### **Long-Term Disability Terminee**

**IMPORTANT:** In order to determine whether you are eligible to continue coverage under the Long-Term Disability Terminee Medical Plan, refer to [Section 4: Eligibility Information](#), for information on the Long-Term Disability Terminee Medical Plan Option.

If you became a Long-Term Disability Terminee before January 1, 2003, you pay 10 percent of the full experience-rated premium (for PreMedicare) or the Sandia-sponsored Medicare Advantage plans (for Medicare), or you will receive 90% of the YSA full credit (if applicable) for you and your covered dependents.

If you were a non-represented employee and were hired or Rehired prior to January 1, 2009, an OPEIU-represented employee who was hired or Rehired prior to July 1, 2009, or an MTC- or SPA-represented employee who was hired or Rehired prior to July 1, 2010, and you became a Long-Term Disability Terminee after December 31, 2002 but prior to January 1, 2012, you pay 35 percent of the full experience-rated premium (for PreMedicare) or the Sandia-sponsored Medicare Advantage plans (Medicare), or you will receive 65% of the YSA credit (if applicable) for you and your covered dependents.

If you were a non-represented employee and were hired or Rehired prior to January 1, 2009, an OPEIU-represented employee who was hired or Rehired prior to July 1, 2009, or an MTC- or SPA-represented employee who was hired or Rehired prior to July 1, 2010, and you became a PreMedicare Long-Term Disability Terminee after December 31, 2011, Sandia will contribute a monthly subsidy toward your Sandia-sponsored group PreMedicare medical coverage. The subsidy will not increase year over year. As healthcare premiums rise, Long Term Disability Terminees will pay the difference between the full experience-rated premium and the subsidy. For Medicare Long-Term Disability Terminee (and any enrolled Medicare dependents), Sandia will provide you with YSA credits to use to purchase individual Medicare plans and/or individual dental plans through Via Benefits. For premium information, refer to the [Benefit Guide for Individuals who Retired Prior to 1/1/2012](#) or the [Benefit Guide for Individuals who Retired After 1/1/2012](#).

If you were a non-represented employee who was hired or rehired on or after January 1, 2009 and you became a Long-Term Disability Terminee, you pay 100 percent of the full experience-



rated premium for you and your covered dependents. If you and/or your covered dependents become Medicare Eligible, you and/or your covered dependents will lose medical coverage through Sandia at the end of the month prior to the month in which you and/or your covered dependents became Medicare Eligible.

If you were an OPEIU-represented employee who was hired or rehired on or after July 1, 2009 and you became a Long-Term Disability Terinee, you pay 100 percent of the full experience-rated premium for you and your covered dependents. If you and/or your covered dependents become Medicare Eligible, you and/or your covered dependents will lose medical coverage through Sandia at the end of the month prior to the month in which you and/or your covered dependents became Medicare Eligible.

If you were an MTC- or SPA-represented employee who was hired or rehired on or after July 1, 2010 and you became a Long-Term Disability Terinee, you pay 100 percent of the full experience-rated premium for you and your covered dependents. If you and/or your covered dependents become Medicare Eligible, you and/or your covered dependents will lose medical coverage through Sandia at the end of the month prior to the month in which you and/or your covered dependents became Medicare Eligible.

## **Class II Premium**

Class II Dependents enrolled prior to 1987 are included in the premium share you pay for yourself and your Class I dependent(s). Any Class II Dependent you enrolled after 1986 and prior to January 1, 2009 (for non-represented employees), July 1, 2009 (for OPEIU-represented employees), or July 1, 2010 (for MTC- and SPA-represented employees) are **not** counted as dependents in calculating the family premium, and you will pay a separate Class II premium. This premium is 70% of the full experience-rated (for PreMedicare) or 70% of the Sandia-sponsored Medicare Advantage plan. If you enroll your Medicare Class II in the YSA option, your Class II Dependent is eligible for 30% of the full YSA credit amount.

## **Billing and Payment Process**

If you and your covered dependents are a “split” family, meaning that one of you is Medicare and the other is PreMedicare, you will receive individual billing statements from Via Benefits.

### ***PreMedicare Participants***

Via Benefits mails out premium statements for medical and dental between the 7th and 10th of each month for the upcoming month. You have until the end of the upcoming month to pay your applicable premium(s). For example, if you receive a billing statement for February, you should receive it mid-January. If you do not remit payment to Via Benefits by the end of February, you may experience a lapse in coverage.

**Note:** If you make a change to your medical and/or dental coverage during Open Enrollment, Via Benefits will mail out your premium statement in mid-December for January.

With every premium statement you receive, Via Benefits will also provide a form to have your premiums automatically debited from your bank account via electronic funds transfer (EFT). You can elect this at any time by completing the form and mailing it to Via Benefits. Please note

that it may take a couple of billing cycles to get this set up, so in the meantime, if you receive any premium statements from Via Benefits, you should remit payment. Individuals with EFT will not receive a monthly bill or statement. Individuals who may pay for a month or two in advance also will not receive a billing statement for the next month.

### ***Medicare Participants***

#### **Sandia Group-Sponsored Medicare Advantage Plans**

Via Benefits mails out premium statements for medical and dental between the 7th and 10th of each month for the upcoming month. You have until the end of the upcoming month to pay your applicable premium(s). For example, if you receive a billing statement for February, you should receive it mid-January. If you do not remit payment to Via Benefits by the end of February, you may experience a lapse in coverage.

**Note:** If you make a change to your medical and/or dental coverage during Open Enrollment, Via Benefits will mail out your premium statement in mid-December for January.

With every premium statement you receive, Via Benefits will also provide a form to have your premiums automatically debited from your bank account via electronic funds transfer (EFT). You can elect this feature at any time by completing the form and mailing it to Via Benefits. Please note that it may take a couple of months to get this set up, so in the meantime, if you receive any premium statements from Via Benefits, you should remit payment. Individuals with EFT will not receive a monthly bill or statement. Individuals who may pay for a month or two in advance also will not receive a billing statement for the next month.

#### **Your Spending Arrangement (YSA) Option**

Billing and invoicing services of the individual Medicare Advantage, Medigap, and Part D plans are provided by the insurance carrier elected by the participant during the enrollment process. Insurance company billing processes vary by carrier. A Via Benefits benefit advisor will assist you with the initial payment during the enrollment process.

If you are also enrolled in the Sandia-sponsored Dental Care Program, please refer to the billing and payment process above under Medicare Advantage Plans for information on your billing statement and remittance of premium.

Refer to the [Your Spending Arrangement \(YSA\) Program Summary](#) for more information.

## Section 7. General Information

This section provides information on the Program Summary materials or Evidence of Coverage (for the Sandia-sponsored Medicare Advantage plans), pre-existing condition limitations, lifetime maximums, general provider network information, and required ERISA notices.

### Program Summary Material

The Program Summary materials and/or Evidence of Coverage information for the medical programs or Dental Care Program in which you are enrolled will be sent to you. If you do not receive the applicable Program Summary materials and/or Evidence of Coverage, contact Via Benefits at 888-598-7809. If you do not receive the applicable Evidence of Coverage, please contact the insurance carrier.

Information about your Sandia Total Health program, the Sandia-sponsored Medicare Advantage plans, the Dental Care Program, and the YSA Program is available in [Appendix E: Program Summary Materials & Evidence of Coverage\(s\)](#). You may also obtain a copy of these materials by contacting Via Benefits at 888-598-7809.

The self-funded Program Summary material listed in [Appendix E: Program Summary Materials & Evidence of Coverage\(s\)](#) describes the nature of covered services including, but not limited to:

- Coverage of drugs, emergency care, preventive care, medical tests and procedures, hospitalization and durable medical equipment;
- Eligibility to receive services;
- Exclusions and limitations;
- Cost sharing (including deductibles and coinsurance/copayment amounts);
- Annual and lifetime maximums and other caps or limits;
- Circumstances under which services may be denied, reduced, or forfeited;
- Procedures, including pre-authorization and utilization review, to be followed in obtaining services; and
- Procedures available for the review of denied claims.

### Pre-existing Conditions Limitations

When you enroll in the Sandia Total Health (administered by UnitedHealthcare (UHC), Blue Cross Blue Shield of New Mexico (BCBSNM for medical), or Kaiser Permanente of Northern California), you will not be excluded from enrollment based on your health, nor will your premium or level of benefits be based on any pre-existing condition limitations.

When you enroll in the UnitedHealthcare Group Medicare Advantage PPO Plan, the Humana Medicare Employer HMO Plan, or the Kaiser Senior Advantage Plan, you generally will not be excluded from enrollment based on your health, nor will your premium or level of benefits be based on any pre-existing condition limitations.

When you enroll into an individual qualified Medicare Advantage or Part D prescription drug plan through the YSA option, you will NOT be excluded from enrollment based on your health, nor will your premium or level of benefits be based on any pre-existing condition limitations. When you enroll into an individual Medicare Supplement plan through the YSA option, **you must do so within 63 days from the loss of your Sandia-sponsored group coverage (whether it is one of the Sandia-sponsored group Medicare Advantage plans or one of the Sandia Total Health programs)**. If you enroll within the 63-day window after loss of coverage, you will not be denied coverage or pay more for your coverage. If you wait to enroll until after the 63-day window, you can be declined coverage or be charged more for the coverage based on your health history.

**IMPORTANT:** If you are enrolled in an individual plan through the YSA option, and you want to upgrade your Medigap plan (e.g., from Plan F to Plan N), individual carriers have the right to underwrite on past health experience, and most do, so you may not be able to upgrade your coverage. In addition, if you want to change carriers, you may also be subject to underwriting.

When you enroll in the Dental Care Program, you will not be excluded from enrollment based on your health, nor will your premium or level of benefits be based on any pre-existing health conditions.

## **Lifetime Maximums**

The Sandia Total Health Programs do not have any lifetime dollar maximums.

The Dental Care Program has a \$1,800 per person lifetime orthodontic maximum benefit.

## **Provider Networks**

If you are enrolled in one of the Sandia Total Health programs or the Dental Care Program that offers benefits through provider networks, a list of providers will be provided to you without charge after your coverage takes effect. If you are enrolled in a Sandia-sponsored Medicare Advantage plan, you will receive a list of the providers from the insurance carrier.

If you enroll in an individual Medicare Advantage plan, the insurance company will provide network information to you upon request. If you enroll in a Medicare Supplement plan, you must see providers who accept Medicare patients. No network is required.

You can also obtain provider directories by contacting the medical or dental Program directly at the address or phone number listed in [Appendix A: Claims and Appeals Administrative Information](#). You may also contact Via Benefits at 1-888-598-7809. For the most up-to-date listing of providers, it is recommended that you log on to the Claims Administrator's website to find out current in-network providers.

Refer to the self-funded Program Summary material in [Appendix E](#) for a description of:

- How to use network providers,
- The composition of the network,
- The circumstances under which coverage will be provided for out-of-network services, and
- Any conditions or limits on the selection of primary care providers or specialty medical providers that may apply.

## **Required ERISA Notices**

### ***Maternity Hospital Stays (Newborns' and Mothers' Health Protection Act) - applicable to Sandia Total Health***

Federal law protects the benefit rights of mothers and newborns related to hospital stays in connection with childbirth. In general, group health programs and health insurance issuers may not:

- Restrict benefits for the length of hospital stay for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean Section. However, federal law generally does allow the mother's or newborn's attending physician, after consulting with the mother, to discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable).
- Require that a physician obtain authorization from the plan or the insurance issuer for prescribing a length of stay of up to 48 hours following a vaginal delivery (or 96 hours following a Cesarean Section).

For details on any state maternity laws that may apply to your medical program, please refer to the Program Summary material listed in [Appendix E](#) for the medical Program in which you are enrolled.

### ***Benefits for Mastectomy-Related Services (Women's Health and Cancer Rights Act) – applicable to Sandia Total Health***

The Sandia Total Health programs will not restrict benefits if you or your dependent:

- Receives benefits for a mastectomy, and
- 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 you or your dependent's physician 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; and
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

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

***HIPAA Privacy Practices***

To review the Sandia National Laboratories Health Plans Notice of Privacy Practices, go to [hr.sandia.gov](http://hr.sandia.gov) and search “HIPAA.”

## Section 8. Coordination of Benefits (COB)

This section defines and explains the 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 the Sandia Total Health or Dental Care Programs by the same type of coverage provided by another group health plan. For coordination of benefits information when you have Medicare, refer to the [Coordination of Benefits with Medicare](#).

**IMPORTANT:** Refer to the Coordination of Benefits section of each Program Summary to find out the specific requirements, if any, for that Program.

### Policy

All benefits for which you enroll under the Sandia Total Health Programs or Dental Care Program are subject to coordination with the benefits of other health coverage under other group health plans including Medicare, if medical expenses are considered covered expenses under the Sandia Total Health or Dental Care Programs. Covered expense for this section means any expense that is eligible for reimbursement by a Sandia medical or dental Program during a claim period. Any covered expense that is not payable by the primary non-Sandia-sponsored health 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, will not be eligible for reimbursement under the Sandia Total Health or Dental Care Programs.

If your other health plans, including Medicare, do not cover a health service that is covered under the Sandia Total Health or Dental Care Programs, the Sandia Total Health or Dental Care Programs will pay as primary for the covered health service.

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under the Sandia Health Benefits Plan for Retirees and other plans. The Plan has the right to release or obtain any information and make or recover any payments considered necessary to administer Coordination of Benefits. This shall include getting the facts needed from, or giving them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must provide any facts needed to apply those rules and determine benefits payable. If you do not provide the information needed to apply these rules and determine the benefits payable, your claim for benefits will be denied.

**Note:** The Sandia Dental Care Program contains a non-duplication of benefits provision. Refer to the Coordination of Benefits section in the Dental Care Program for more information on how that Program coordinates benefits.

If your PreMedicare covered dependent has primary prescription drug coverage through a non-Sandia-sponsored medical plan, including Medicare, your covered dependent is not eligible to

use the mail order service through your PreMedicare medical Program. In addition, your covered dependent will only have secondary coverage under the retail pharmacy benefit. Refer to your Sandia Total Health Program Summary for more information. This provision does not apply to the Humana Medicare Employer HMO Plan, the UnitedHealthcare Group Medicare Advantage PPO Plan, the Kaiser Senior Advantage Plan, or the individual Medicare plans through the YSA option.

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

The Coordination of Benefits (COB) applies only to group health plans and not to individual insurance and does not apply when married persons are both members in Sandia’s medical or dental Programs.

**IMPORTANT:** If you are enrolled in one of the Sandia-sponsored Medicare Advantage Programs or a Medicare plan through the YSA option and you subsequently enroll in a non-Sandia-sponsored Medicare Advantage Program or a Medicare Part D plan, you will be disenrolled from the Sandia-sponsored Medicare Advantage Program or your Medicare plan, as Medicare does not allow dual enrollment.

If you or your covered dependents are also covered under another medical or dental Program, use the table below to determine which Program pays for Primary Coverage and which Program pays for secondary coverage.

If...	Then...
The other Program (including HMOs) does not have a COB provision,	The Program with no COB provision is primary
Both Programs have COB provisions	The Program covering the person as a Retiree is primary and pays benefits up to the limits of that Program. The Program covering the person as a dependent is secondary and pays the remaining costs to the extent of coverage
Both Programs have COB provisions and use the birthday rule for dependent children coverage	The Program covering the parent whose birthday comes first (month and day) in the year is the primary Program and pays benefits first. The Program covering the other parent is secondary and pays the remaining costs to the extent of coverage
Both Programs have COB but neither Program 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 Program and pays benefits first. The mother’s group insurance is secondary and pays the remaining costs to the extent of her coverage
Both Programs 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 Program and pays benefits first. The mother’s group insurance is secondary and pays the remaining costs to the extent of her coverage
A divorce or legal decree establishes financial responsibility for health care for the covered dependent children	The parent who has the responsibility is the holder of the primary program



If...	Then...
A divorce decree does not establish financial responsibility for health care of the dependent	The program of the parent with custody is the primary program; the other parent's program is secondary
A divorce decree does not establish financial responsibility and assigns joint custody	Each parent is primary when the child is living in that parent's home
A divorce decree does not establish financial responsibility, and the parent with custody remarries	The custodial parent's program remains primary; the stepparent's program is secondary; the noncustodial parent's program is third
Payment responsibilities are still undetermined	The program that has covered the patient for the longest time is the primary program

## Coordination of Benefits with Medicare

Whether Medicare pays first depends on many things, including the situations listed in the chart. However, this chart doesn't cover every situation. Be sure to tell your doctor and other providers if you have coverage in addition to Medicare. This will help them send your bills to the correct payer to avoid delays. If you have questions about who pays first, or if your insurance changes, call the Medicare Coordination of Benefits Contractor (COBC) at 800-999-1118. TTY users should call 800-318-8782.

The following table presents many scenarios on how the sequence of coverage applies under coordination with Medicare, assuming you, your Spouse, or other covered dependent is eligible for Medicare A & B and enrolled in Medicare Part A & B.

If you...	Are enrolled in	Primary Payor is...	Secondary Payor is...	Last Payor is...
Retire from Sandia and have no coverage from any other plan	Sandia-sponsored Medicare Advantage Plan	Your Sandia-sponsored Medicare Advantage Plan. <sup>1</sup>	Not applicable	Not applicable
	An individual Medicare medical plan through YSA	Your individual Medicare medical plan.	Not applicable	Not applicable
Retire from Sandia, enroll for benefits at your new job, age 65 or over, and enroll in Medicare	Sandia-sponsored Medicare Advantage Plan	Your new employer group plan	Not eligible to enroll.	Any other coverage you have
	An individual Medicare medical plan through YSA	Your new employer group plan	Individual medical and/or prescription Part D plan	Any other coverage you have
Retire from Sandia and enroll for benefits at a new job and do not enroll in Medicare	Sandia-sponsored Medicare Advantage Plan	Your new employer group plan	Not eligible to enroll	Any other coverage you have
	An individual Medicare medical plan through YSA	Your new employer group plan	Not eligible to enroll	Any other coverage you have

<b>If you...</b>	<b>Are enrolled in</b>	<b>Primary Payor is...</b>	<b>Secondary Payor is...</b>	<b>Last Payor is...</b>
Are age 65 or over and are the enrolled dependent of an employee who continues to work at Sandia after age 65 and you enroll in Medicare	Sandia-sponsored Medicare Advantage Plan	Employee plan	Not eligible to enroll	Any other coverage you have
	An individual Medicare medical plan through YSA	Employee plan	Not eligible to enroll	Any other coverage you have
Are age 65 or over and the enrolled dependent of an employee who works somewhere other than Sandia after age 65 and you enroll in Medicare	Sandia-sponsored Medicare Advantage Plan	Spouse's plan	Sandia-sponsored Medicare Advantage Plan <sup>1</sup>	Any other coverage you have
	An individual Medicare medical plan through YSA	Spouse's plan	Individual Medicare medical and/or prescription Part D plan	Any other coverage you have
Are disabled and enrolled in Medicare and are the enrolled dependent of a Retiree	Sandia-sponsored Medicare Advantage Plan	Your Sandia-sponsored Medicare Advantage Plan. <sup>1</sup>	Not applicable	Not applicable
	An individual Medicare medical plan through YSA	Individual Medicare medical and/or prescription Part D plan	Any other coverage you have	Not applicable
Retire from Sandia and are enrolled in Tricare for Life	Sandia-sponsored Medicare Advantage Plan	Your Sandia-sponsored Medicare Advantage Plan. <sup>1</sup>	Tricare for Life	Not applicable
	An individual Medicare medical plan through YSA	Your individual Medicare medical plan and/or prescription Part D plan	Any other coverage you have	Tricare for Life

<sup>1</sup> You are required to assign your benefits to the Program. You do not have a separate Medicare benefit.

## **Injuries or Illnesses Alleged to be caused by a Third Party**

**IMPORTANT:** If you are enrolled in one of the Sandia-sponsored Medicare Advantage plans or a Medicare plan through the YSA option, you will need to refer to the applicable Evidence of Coverage for information on this provision.

When you or your covered dependent are injured or become ill because of the actions or inactions of a third party, the Sandia Health Plan for Retirees may cover your eligible healthcare (medical, prescription drug, and dental) expenses. However, to receive coverage, you must notify the Sandia Health Plan for Retirees that your illness or injury was caused by a third party, and you must follow special Sandia Health Plan for Retirees rules. This section describes the Sandia Health Plan for Retirees' procedures with respect to subrogation and right of recovery.

Subrogation means that if an injury or illness is someone else's fault, the Sandia Health Plan for Retirees has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the Sandia Health Plan for Retirees has the right to recover such expenses directly out of any payment made to you by the at-fault party or any other party related to the illness or injury.

By accepting Sandia Health Plan for Retirees benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that the Sandia Health Plan for Retirees:

- Has an equitable lien on any and all monies paid, or payable to you, or for your benefit by any responsible party or other recovery to the extent the Sandia Health Plan for Retirees paid benefits for such illness or injury;
- May appoint you as constructive trustee for any and all monies paid, or payable to you, for your benefit by any responsible party or other recovery to the extent the Sandia Health Plan for Retirees paid benefits for such illness or injury; and
- May bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the illness or injury.

If you, your attorney, or other representative receive any payment from the sources listed later in this section – through a judgment, settlement or otherwise – when an illness or injury is a result of a third party, you agree to place the funds in a separate, identifiable account and that the Sandia Health Plan for Retirees has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the Sandia Health Plan for Retirees has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must pay the Sandia Health Plan for Retirees back first, in full, out of such funds for any health care expenses the Sandia Health Plan for Retirees has paid related to such illness or injury. You must pay the Sandia Health Plan for Retirees back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses.

The “make whole” doctrine does not apply and does not limit the Sandia Health Plan for Retirees' right to recover amounts it has paid on your behalf. Furthermore, you must pay the Sandia Health Plan for Retirees back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury. If any money is left over, you may keep it.

Additionally, the Sandia Health Plan for Retirees is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) you incur in obtaining the funds.

The Sandia Health Plan for Retirees' sources of payment through subrogation or recovery includes (but is not limited to) the following:

- Money from a third party that you, your guardian or other representative(s) receive or are entitled to receive;

- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representative(s) receive;
- Any equitable lien on the portion of the total recovery which is due the Sandia Health Plan for Retirees for benefits it paid; and
- Any liability or other insurance (for example, uninsured motorist, under insured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representative(s)

As a Sandia Health Plan for Retirees participant, you are required to:

- Cooperate with the Sandia Health Plan for Retirees' efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to prejudice the Sandia Health Plan for Retirees' subrogation or recovery rights outlined in this Summary.
- Notify the Sandia Health Plan for Retirees within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.
- Provide all information requested by the Sandia Health Plan for Retirees, the Claims Administrator or their representatives, or the Sandia Health Plan for Retirees Administrator or its representatives.
- Execute and deliver such documents as may be required and do whatever else is needed to secure the Sandia Health Plan for Retirees rights.

The Sandia Health Plan for Retirees may terminate your participation and/or offset your future benefits for the value of benefits advanced in the event that the Sandia Health Plan for Retirees does not recover, if you do not provide the information, authorizations, or otherwise cooperate in a manner that the Sandia Health Plan for Retirees considers necessary to exercise its rights or privileges under the Sandia Health Plan for Retirees.

If these subrogation provisions conflict with subrogation provisions in an insurance contract governing benefits at issue, the subrogation provisions in the insurance contracts will govern. If these right of recovery provisions conflict with right of recovery provisions in an insurance contract governing benefits at issue, the right of recovery provisions in the insurance contract will govern.

All Sandia Health Plan for Retirees rights under this section remain enforceable against the heirs and estate of any covered person.

Failure to comply with the health's subrogation and recovery rules may result in termination of coverage for cause as well as legal action by the health plan to recover benefits paid that would otherwise have been subject to subrogation or recovery under these provisions.

**Note:** If the injured party is a minor dependent, the primary subscriber must comply with the above agreement and/or duties.

## Section 9. Medicare and the Sandia Retiree Health Benefits Plan

This section outlines some basic information about Medicare and how these benefits interact with the Sandia Health Benefits Plan for Retirees.

**Note:** Upon becoming Medicare Eligible, certain Retirees can continue coverage under Sandia's Dental Care Plan (refer to [Section 4: Eligibility Information](#)).

### What is Medicare

Medicare, administered by the Social Security Administration, is the U.S. federal government health insurance program for:

- People age 65 or older
- People under age 65 with certain disabilities
- People of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant)

Medicare benefits are provided regardless of income level.

Health coverage under Medicare includes Parts A, B, and D. The following highlights the Medicare Parts A, B, and D and the coverage Medicare provides under each part.

Medicare Part A (Hospital Insurance Plan) covers:

- Hospital benefits
- Hospice care
- Home health services
- Skilled nursing facilities (not including nursing homes)

Persons age 65 and over who have more than 10 years of Medicare-covered employment, whether retired or still working (and Spouses of those persons who are age 65 or over), automatically receive Part A coverage at no cost.

**IMPORTANT:** If your dependent has not worked enough to qualify for Medicare Part A on their own, your dependent can purchase Medicare Part A. However, if your dependent does not qualify for no-cost Part A due to insufficient Medicare-covered employment, once you turn 62, your dependent is then eligible for Part A at no cost, and you must purchase Medicare Part A. If you are under age 62 and your dependent is not a US citizen, and therefore is unable to purchase Medicare, your dependent can enroll into one of the PreMedicare medical plans until becoming a US citizen and eligible to purchase Medicare.

If you are not eligible for free Medicare Part A coverage, you may enroll by paying the full premium to Medicare.

Medicare Part B (Medical Insurance Plan) covers a portion of the following types of charges after an annual Medicare deductible is met:

- Physician services
- Medical services
- Outpatient diagnostic or treatment services

Persons eligible for Medicare Part A can purchase Part B by paying a monthly Medicare premium. The payment is normally deducted from the Social Security benefit. The Part B premium is subject to income adjustments.

Medicare Part D (Prescription Drug Insurance Plan) covers a portion of your prescription drug costs.

## **Enrolling in Medicare**

**IMPORTANT:** If you are eligible for Medicare and elect coverage under one of the Sandia-sponsored Medicare Advantage plans (Kaiser Senior Advantage Plan, UnitedHealthcare Group Medicare Advantage PPO Plan, or Humana Medicare Employer HMO Plan), or the YSA Program, you must be covered under both Medicare Part A and B. If you are not enrolled in Medicare Parts A and B prior to the month in which you become Medicare Eligible, Via Benefits will not be able to enroll you in a medical plan and you will lose coverage with Sandia. In addition, if you elect to delay enrollment in Medicare Part B, if you choose to enroll at a later date you may be subject to a Medicare penalty.

### ***Part A Enrollment***

In general, you will automatically get Medicare Part A if you are already getting benefits from Social Security, starting the first day of the month you turn age 65, or if you are under age 65 and disabled and have received disability benefits from Social Security for 24 months.

If you aren't automatically enrolled in Medicare Part A and you are eligible for Medicare, call the Social Security Administration at 800-772-1213 or visit [www.medicare.gov](http://www.medicare.gov) for more information.

Most people don't have to pay for Medicare Part A if they or their Spouse worked 10 or more years in Medicare-covered employment.

### ***Part B Enrollment***

**IMPORTANT:** Failure to enroll in Medicare Part B will result in termination of your medical coverage through Sandia.

If you are close to age 65 and you don't currently get Social Security or Railroad Retirement benefits, or Medicare Part A, you can sign up for Medicare Part B when you apply for retirement benefits or Medicare Part A.

If you aren't automatically enrolled in Medicare Part B, you will need to contact the Social Security Administration at 800-772-1213.

The following are the Medicare enrollment opportunities for you to enroll in Medicare Parts B if you are eligible for Medicare.

- Initial Enrollment Period is a seven-month period that consists of the three months before the month you turn age 65, the month in which you turn 65, and the three months after you turn age 65.
- General Enrollment Period runs from January 1 through March 31 of each year. Medicare coverage will start on July 1 of the year you sign up. A penalty of 10% per year for every year you did not enroll in Medicare can be added to the monthly Medicare Part B premiums.

The cost of Medicare Part B goes up 10 percent for each full 12-month period that you could have taken Medicare Part B (for special case exceptions contact your Social Security office)

- Special Enrollment Period is available if you are eligible for Medicare based on age 65 or disability, but you waited to enroll in Medicare Part B because you or your Spouse were working and you had employer group health coverage as your Primary Coverage.

If this applies to you, you are eligible to sign up for Medicare Part B anytime while you are covered by the employer group health plan based on current employment status or during the eight-month period following the month the group health plan coverage ends or the employment ends, whichever is first.

The special enrollment period allows you to enroll in Medicare Part B without having to pay the additional 10 percent premium for each full 12-month period that you delayed enrollment in Medicare Part B.

For more information about signing up for Medicare Parts A and B, contact the Social Security Administration, at 800-772-1213, or your local Social Security office.

### ***Part D Enrollment***

Part D refers to optional prescription drug coverage, which is available to all people who are eligible for Medicare. Each of the Sandia-sponsored Medicare Advantage plans offers prescription drug coverage so you do not need to separately enroll in a Medicare Part D plan in order to receive prescription drug benefits. If you elect the YSA Program, you will be given the choice of several Part D plans you can purchase with your YSA credits.

### **Sandia-Sponsored Medicare Advantage Plans**

Medicare Advantage Plans are health plan options (like an HMO or PPO) approved by Medicare. Sandia offers three Medicare Advantage Programs – the Humana Medicare Employer HMO Plan, the UnitedHealthcare Group Medicare Advantage PPO Plan, and the Kaiser Senior Advantage Plan. Refer to the applicable Evidence of Coverage for eligibility, covered Service Areas, associated benefits, and plan rules. These Sandia-sponsored Medicare Advantage plans are not available to every Medicare individual. Refer to the [Section 1: Introduction](#) for more information.

These plans are part of Medicare and are sometimes called “Part C” or Medicare Advantage Prescription Drug (MAPD) Plans. These companies must follow rules set by Medicare. The Sandia-sponsored Medicare Advantage Plans provide your Medicare health coverage (including your Part A – hospital insurance and Part B – medical insurance) and your Medicare drug coverage. If you enroll in one of the Programs, you will be required to assign your Medicare benefits to the Program.

If you are eligible for Medicare and elect coverage under one of the Medicare Advantage Programs, there are generally no claims to file, and since you assign your benefits to the Program, there is no coordination of benefits with Medicare.

You and/or your eligible Medicare dependents can join one of the Medicare Advantage Programs through Sandia if you and/or your eligible Medicare dependents meet these conditions:

- You have Medicare Part A and Part B
- You live in the Service Area of the plan
- Generally, if you don’t have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). Refer to the applicable Evidence of Coverage for more information.

**IMPORTANT:** If you are enrolled in one of the Sandia-sponsored Medicare Advantage Programs and you subsequently enroll in a non-Sandia-sponsored Medicare Advantage Program or a Medicare Part D plan, you will be disenrolled from the Sandia-sponsored Medicare Advantage Program as Medicare does not allow dual enrollment.

## **Your Spending Arrangement (YSA) Program**

You and/or your eligible Medicare dependents can enroll in the YSA Program as long as you have Medicare Part A and Part B.

The YSA option provides you with “credits” to use to buy individual supplemental Medicare plans through Via Benefits. You will have access to a wide range of Medicare plans through Via Benefits’ Exchange, allowing you to choose the plan(s) that best fits your medical and prescription drug requirements. You may also be able to use the credits to reimburse any Medicare Part A or Part B premiums and/or use towards certain out-of-pocket medical expenses. A Via Benefits licensed benefit advisor will provide the premium rates in your area. Refer to the [Your Spending Arrangement \(YSA\) Program Summary](#) for more information.

You cannot enroll in a Sandia-sponsored Medicare Advantage Plan and elect the YSA option. It is an either/or choice.

## **Types of Medicare Supplemental Plans**

The range of plan premiums varies widely. If you elect to enroll in a Medicare Advantage plan, Medigap plan, and/or Part D plan, you must continue to pay your Medicare Part A (if applicable) and Part B premium and any additional premium charged by the plan(s).

**Note:** Not all individual Medicare supplemental plans are available in all areas.



The following table outlines the differences between available Medicare supplemental plans available through Via Benefits' Exchange:

	<b>Medigap Plans</b>	<b>Part D Plans</b>	<b>Medicare Advantage Plans</b>
Description	Supplemental insurance sold by private insurance companies to fill "gaps" in Original Medicare plan coverage. These 10 plans (labeled Plans A, B, C, D, F, G, K, L, M & N) offer standardized menus of benefits.* Generally, there is no prescription drug coverage.	Part D plans are offered through private insurance companies. Part D covers generic and brand-name drugs included in the plan's formulary. Prescription drug plans may be purchased separately or as an add-on for Medicare Advantage plans that do not offer a prescription drug benefit (MA) or Medigap plans.	These plans are offered by private companies to provide you with all your Medicare Part A and Part B benefits plus additional benefits. There are two versions: Medicare Advantage Prescription Drug (MAPD) and Medicare Advantage (MA). MAPD plans include prescription drug coverage, MA plans do not.
Deductibles, Copayments, Coinsurance	Most Medigap services are covered with no additional out-of-pocket cost to you. There are no deductibles or coinsurance.	Wide range of copayments, deductibles, and coinsurance.	Most plans require a copayment or coinsurance at the time of service.
Does it include hospital coverage?	Yes	Not applicable	Yes
Does it cover doctors and specialists?	Doctors and specialists are covered. Any doctor that accepts original Medicare accepts these plans.	Not applicable.	Doctors and specialists are covered. There are three types of doctor networks: Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), and Private Fee for Service.
Does it have prescription drug coverage?	Prescription drugs are not covered. You must enroll separately in a Part D plan.	Yes	There are two versions: MAPD which includes prescription drugs and MA, which does not.
Does it have dental and vision benefits?	No	No	Dental and vision coverage varies by plan.
Does it cover me when I travel?	These plans are accepted by every Medicare-participating provider in the U.S. with some emergency benefits worldwide. If you travel frequently or live part of the year out-of-state, these plans may be right for you.	These plans provide nationwide coverage through participating pharmacies.	These plans cover urgent and emergency care nationwide, but some may not provide nationwide coverage for non-emergency services. If you live part of the year out-of-state, these plans may not be right for you.
* Massachusetts, Minnesota, and Wisconsin have their own versions of these plans.			

## Section 10. Claims and Appeals Procedures

This section provides general information regarding claims and appeals procedures applicable to the self-funded medical or dental Programs. If you are enrolled in one of the Sandia-sponsored Medicare Advantage plans or an individual plan through the YSA Program, please refer to your plan's Evidence of Coverage for Claims and Appeals Procedures. If you are enrolled in the Sandia Total Health Program, refer to the applicable Program Summary for information on submission of Health Reimbursement Account (HRA) claims.

**IMPORTANT:** For specific claims and appeals procedures for a claim for benefits, refer to the applicable Program Summary listed in [Appendix E](#).

The Plan's claims, appeals, and review procedures shall comply with ERISA regulations and, to the extent applicable, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act, and as interpreted by applicable guidance and regulations from the relevant government agencies.

In performing their obligation to process and adjudicate claims for plan benefits, the claims administrators listed in [Appendix A](#) act as fiduciaries, as defined by and in compliance with applicable provisions of ERISA. Sandia accordingly delegates to the claims administrator the discretionary authority necessary to fulfill this role. As the claims fiduciary, the claims administrator has the sole authority and discretion to determine whether submitted services/costs are eligible for benefits and to interpret, construe, and apply the provisions of their respective Program (with the exception of a claim that is applicable only to member eligibility provisions which, except for incapacitated dependent status, are determined by Sandia) in processing and adjudicating claims.

**IMPORTANT:** All claims must be submitted within one year after the date of service (certain exceptions apply to the YSA Program to be eligible for consideration of payment. The one-year requirement will not apply if you are legally incapacitated. If your claim relates to a hospital stay, the date of service is the date your hospital stay ends.

Upon written request and free of charge, a participant may examine documents relevant to his/her claim and submit opinions and comments. The claims procedures for each specific Program will be furnished to you without charge. If you do not receive the claims procedures, please contact Via Benefits at 888-598-7809.

### Benefits Payment

Refer to the applicable medical or dental Program for specific information on benefits payments. In general, if the service is rendered in-network, payment will be made directly to the provider. If the service is rendered out-of-network, payment will be made directly to the employee. Refer to the YSA Program regarding benefit payments.

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

If any benefits of your medical or dental Program are payable to the estate of a covered member or to a minor or individual who is incompetent to give valid release, the Claims Administrator may pay such benefits to any relative or other person whom the Claims Administrator determines to have accepted competent responsibility for said minor or individual who is incompetent and who is able to give a valid release or as otherwise required by law. Any payment made by the medical or dental Program in good faith pursuant to the provision shall fully discharge the medical or dental Program and Sandia to the extent of such payment.

Members cannot assign, pledge, borrow against, or otherwise promise any benefit payable under the Sandia medical or dental Programs before receipt of that benefit. Your interest in your medical or dental Program is not subject to the claims of creditors. Exceptions include:

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

On occasion, there are outstanding benefit payment checks that have been paid by a Claims Administrator for the Programs but have not been cashed and have been stale-dated. In this case, the Primary Covered Member must notify the claims administrator or Via Benefits within two calendar years from the end of the Plan year in which the service was rendered to claim funds; otherwise the monies will be forfeited.

## **Filing an Initial Claim**

You must follow the claims procedures established by the medical or dental Programs. If you need a claim form, you may call your Claims Administrator (phone number on back of member ID card) or log on to your Claims Administrator's website to obtain a claim form. See [Appendix C](#) of this document for website information. You may also obtain a claim form from the Sandia HR website ([hr.sandia.gov](http://hr.sandia.gov)).

**Note:** Presentation of a prescription to a pharmacy is not in and of itself considered an initial claim.

### ***Timeframes for Initial Claims Decisions***

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 health care or treatment that has to be decided more quickly because the normal timeframes for decision-making could seriously jeopardize your life or health or your ability to regain maximum function, or in the opinion of a physician with knowledge of your condition, subject you to severe pain that cannot be adequately managed without the care or treatment addressed in the claim. Does not apply to the YSA Program or the Dental Care Program.

- **Pre-service** – a claim for a health benefit – other than an urgent care claim – that must be approved in advance of receiving medical care (for example, requests for pre-certifying a hospital stay or for pre-approval under a utilization review program). Does not apply to the YSA Program or the Dental Care Program. Pre-determination of benefits is available under the Dental Care Program but is not required to receive benefits. Refer to the Dental Care Program for more information.
- **Concurrent care** – a claim for a health benefit which the medical Program – after having previously approved an ongoing course of medical treatment provided over a period of time or a specific number of treatments – subsequently reduces or terminates coverage for the treatments (other than by program amendment or termination). Does not apply to the YSA Program or Dental Care Program.
- **Post-service** – any other type of claim for a health benefit

The following table outlines the general deadlines for the initial determination, identifies whether any extensions are available, and the deadlines if additional information is needed:

	<b>Urgent Care Claims</b>	<b>Pre-Service Claims</b>	<b>Post-Service Claims</b>	<b>Concurrent Care Claims</b>
What is the general deadline for initial determination?	No later than 72 hours from receipt of claim	15 calendar days from receipt of the claim	30 calendar days from receipt of the claim	Must be provided sufficiently in advance to give claimant 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. <b>Note:</b> if the claim is not made at least 24 hours prior to the expiration of the period of time or number of treatments, then the claim reverts to either an urgent care claim, pre-service or post-service claim.
Are there any extensions?	No, but see below for extensions based on insufficient information	Yes. One 15 calendar day extension, if the claims administrator determines it is necessary due to matters beyond its control and informs the claimant of the extension within this time frame	Yes. One 15 calendar day extension, if the claims administrator determines it is necessary due to matters beyond its control and informs the claimant of the extension within this time frame	No

	<b>Urgent Care Claims</b>	<b>Pre-Service Claims</b>	<b>Post-Service Claims</b>	<b>Concurrent Care Claims</b>
What is the deadline if additional information is needed?	<p>Claimant must be notified of the need for additional information within 24 hours of receipt of the claim.</p> <p>Claimant must be given at least 48 hours to respond.</p> <p>The running of time is suspended for 48 hours or until the information is received, whichever is earlier.</p>	<p>If an extension is necessary because claimant failed to provide necessary information, the notice of extension must specify the information needed.</p> <p>Claimant must be given at least 45 calendar days to respond. The running of time for the initial claims determination is stopped until the end of the prescribed response period or until information is received, whichever is earlier. At that point the decision will be made within 15 calendar days.</p>	<p>If an extension is necessary because claimant failed to provide necessary information, the notice of extension must specify the information needed.</p> <p>Claimant must be given at least 45 calendar days to respond. The running of time for the initial claims determination is stopped until the end of the prescribed response period or until information is received, whichever is earlier. At that point the decision will be made within 15 calendar days.</p>	Not applicable

***Notice and Response from the Claims Administrator***

After your claim is reviewed by the Claims Administrator, you will receive a notice of benefit determination within the timeframes specified above. For Urgent Care and Pre-Service claims, you will receive a notice of benefit determination whether or not the Claims Administrator makes an Adverse Decision on your claim. For Post-Service and Concurrent Care Claims, you are entitled to receive a notice of benefit determination if the Claims Administrator makes an Adverse Decision on your claim. The notice of benefit determination will include all of the following:

- Specific reasons for the denial;
- References to the specific 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 that material or information is necessary;

- Description 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;
- If applicable, a copy of any rule, guideline, or protocol 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 an adverse determination is based on medical necessity (or covered health services for UnitedHealthcare) or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse determination (or a statement that such explanation will be provided) free of charge upon request.
- Effective for medical claims incurred on or after January 1, 2012, the notice will include:
  - the date of service;
  - the healthcare provider;
  - the claim amount (if applicable);
  - the denial code;
  - a statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
  - a description of the Sandia Total Health Program’s standard used in denying the claim. For example, a description of the “medical necessity” standard will be included;
  - in addition to the description of the Sandia Total Health Program’s internal appeal procedures, a description of the external review processes; and
  - the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

## **Filing an Appeal**

Medical coverage for you and your dependents will continue pending the outcome of an internal appeal. This means that the Sandia Total Health Program will not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

If the STH Program fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to your medical claim, you are deemed to have exhausted the internal claims and appeals process, regardless of whether the Plan or claims administrator asserts that it has substantially complied with these requirements or that the error was de Minimis. In this case, you may seek an external review or pursue legal remedies (as discussed below) without waiting for further action. Additionally, if your claim is an Urgent Care Claim or a claim requiring an ongoing course of treatment, you may begin an expedited external review before the Sandia Total Health Program’s internal appeals process has been completed.

**IMPORTANT:** Upon denial of a claim, you have 180 calendar days of receipt of the notification of Adverse Benefit determination to appeal the claim. If you enroll in a Sandia-sponsored Medicare Advantage plan please refer to the Evidence of Coverage provided to you or call them directly.

If a claim for benefits is denied in part or in whole, you have the right to appeal the claim. A request for further information (such as a diagnosis) from the provider of service is not a claim denial. The medical Programs (with the exception of the Medicare Advantage Programs and the YSA Program) also have a Voluntary External Review Program.

Except as described above, you must exhaust the mandatory levels of appeals process before you can request an external review or seek other legal recourse. If you don't appeal on time, you lose your right to later object to the decision.

**IMPORTANT:** Regardless of the decision and/or recommendation of the Claims Administrator, Sandia Corporation, or what the Program will pay, it is always up to the member and the doctor to decide what, if any, care he or she receives.

The table below outlines who to contact based on the reason for the claim denial:

If you have a claim denied because of...	Then...
Eligibility (except for incapacitation determinations)	See <a href="#">Eligibility Appeal Procedures</a> .
Eligibility based on incapacitation determinations	Contact the medical or dental claims administrator, whichever is applicable.
Benefit Determinations	See the applicable Program Summary for the appeals procedures. Refer to the Kaiser Senior Advantage Plan, Humana Medicare Employer HMO Plan, or the UnitedHealthcare Group Medicare Advantage PPO Plan Program Summary (also known as the Evidence of Coverage) for specific information on appeal procedures. Refer to the Eligibility Appeal Procedures if you have a claim denied by a claim administrator based solely on eligibility.

For medical claims, the claims administrator will ensure that all claims and appeals are adjudicated in a manner designed to ensure there is no conflict of interest with regard to the individual making the decision. The claims administrator will ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. The claims administrator will ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, rather than based on the professional's qualifications.

You will be able to review your file and present evidence as part of the review. In addition, prior to making a benefit determination on review, the claims administrator must provide you with any new or additional evidence considered, relied upon, or generated by the Sandia Total Health Program (or at the direction of the Sandia Total Health Program) in connection with the claim.

This evidence will be provided at no cost to you and will be given before the determination in order to give you a reasonable opportunity to respond.

Prior to issuing a final internal adverse benefit determination on review based on a new or additional rationale, the rationale will be provided at no cost to you. It will be given before the determination in order to give you a reasonable opportunity to respond.

***Timeframes for Appeals Decisions***

The table below outlines general appeal deadlines by which a claimant must be notified of an appeals decision as well as the mandatory level of reviews for each claim (see the specific Program summary for the appeal procedures):

	<b>Urgent Care Claim</b>	<b>Pre-Service Claim</b>	<b>Post-Service Claim</b>
<b>Appeal deadline by which a claimant will be notified of appeals decision</b>	As soon as possible taking into account medical exigencies, but no more than 72 hours. Note: You do not need to submit the claim appeal in writing. Call the Claims Administrator as soon as possible to appeal a claim. Does not apply to the YSA Program.	For the first level of appeal, 15 calendar days from receipt of appeal. For the second level of appeal, 15 calendar days from receipt of the appeal for each level. Note: Pre-Service Claims are not applicable under the Dental Care Program, but a non-ERISA appeals process does apply to Pre-determination of Benefits. Refer to the Dental Care Program Summary. Does not apply to the YSA Program.	For the first level of appeal, 30 calendar days from receipt of appeal. For the second level of appeal, 30 calendar days from receipt of the appeal for each level.

**Note:** An appeal of a concurrent care claim decision to reduce or terminate previously approved benefits may be an urgent care, pre-service or post-service claim depending on the facts.

**Your Right to Information**

If the appeal is denied, the notification will:

- Explain the specific reasons and specific Plan provisions on which the decision is based;
- Include a statement describing any voluntary appeal procedures offered by the Plan and the Claimant’s right to obtain information about these procedures;
- Include a statement regarding the Claimant’s right to bring a civil action under ERISA 502(a); and
- Offer to provide the Claimant, on request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

You are also entitled to access and copy any internal rule, guideline, protocol, or other similar criteria used as a basis for a decision on your denied claim or appeal upon request, free of charge. Similarly, if your claim or appeal is denied based on a determination involving a medical or dental care judgment, you are entitled to an explanation of the scientific or clinical reasons for that determination, free of charge upon request.



For Sandia Total Health Program claim adverse benefit determinations, the notice will also include the following information:

- The date of service;
- The health care provider;
- The claim amount (if applicable);
- The denial code;
- A statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- A description of the Sandia Total Health Program’s standard used in denying the claim. For example, a description of the “medical necessity” standard will be included;
- In addition to the description of the Sandia Total Health Program’s internal appeal procedures, a description of the external review processes; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

## **External Review Program**

For claims involving medical judgment, as determined by the external reviewer, or a coverage rescission, you are entitled to request an independent, external review of the decision. You must request the external review within four (4) months of the date you receive an adverse benefit determination. The External Review Programs are described in each Sandia Total Health Program Summary. If your claim relates to a need for urgent care or receipt of an on-going course of treatment, you may start an expedited external review while the Sandia Total Health Program’s appeals process is underway. If your request for an external review is determined eligible for such a review, an independent organization will review the claims administrator’s decision and provide you with a written determination, generally within 45 days.

The Sandia Total Health Program’s external review process will follow the process set forth in the NAIC Uniform Model Act. The external review decision is binding on you and the Plan, except to the extent that other remedies are available under federal law.

The external review process does not apply to an adverse benefit determination or final internal adverse benefit determination that relates to a participant’s or beneficiary’s failure to meet the requirements for eligibility under the terms of a group health plan (for example, worker classification and similar issues) or that is not related to medical judgment or coverage rescission.

**IMPORTANT:** The deadline for submitting a request for an informal or formal review of your eligibility to the Sandia Health Plans Team will be 180 days after you receive written notification of the denial of the claim by the claims administrator or a Sandia-sponsored Medicare Advantage Program or denied participation by Via Benefits to enroll in a medical and/or dental Program. Once final resolution has been reached on your eligibility appeal by Via Benefits, you then have 180 days (from the date of the written notification by Via Benefits) to appeal your denied claim

for benefits with the claim administrator. Please note that for the Sandia-sponsored Medicare Advantage Program, no retroactive enrollment is permitted. Therefore, if the decision is overturned, your coverage will be effective the beginning of the month after which Sandia forwards your enrollment paperwork.

## **Eligibility Appeal Procedures**

You may use the eligibility appeals procedure to request an informal review, a formal review, or both, if:

- You or your dependent(s) had a benefit claim that was denied by a claims administrator or a Sandia-sponsored Medicare Advantage Program based solely on eligibility, or
- You or your dependent(s) have been informed by Via Benefits that either you or your dependent(s) are not eligible for participation in the Sandia Health Plan for Retirees (e.g., your dependent is denied eligibility to participate in your medical Program or you missed the enrollment window).

### ***Request for Informal Review***

You have the option to request an informal review of your appeal for eligibility by contacting Via Benefits at 1-888-598-7809. Via Benefits will review all pertinent information and render a written decision as soon as possible but no later than fourteen (14) calendar days of the receipt of all material facts. If you are not satisfied with the decision of Via Benefits, you can request a formal review.

### ***Request for Formal Review***

To request a formal review of a denial based solely on eligibility to participate in the Sandia Health Benefits Plan for Retirees, you must submit an appeal in writing to the Secretary of the Employee Benefits Committee, c/o Sandia Health Plans Team, PO Box 5800, Albuquerque, NM 87185, MS 1022. If the denied claim is based on any reason other than eligibility, you must file the appeal with the appropriate claims administrator listed in [Appendix A](#). You will receive a response to your appeal based on the following time frame:

- If an urgent care claim, within 72 hours of receipt of the appeal
- If a pre-service claim, within 30 calendar days of receipt of the appeal
- If a post-service claim, within 60 calendar days of receipt of the appeal

If the appeal related solely to eligibility is denied, the notification will:

- Explain the specific reasons and specific Plan provisions on which the decision is based;
- Include a statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain information about these procedures;
- Include a statement regarding the Claimant's right to bring a civil action under ERISA 502(a); and
- Offer to provide the Claimant, on request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your eligibility claim.

A claim or appeal regarding eligibility may be filed by an authorized representative on behalf of a Claimant. If your appeal is denied by the Employee Benefits Committee, you can appeal to the Employee Benefits Claim Review Committee (EBCRC). The EBCRC will be the final and conclusive administrative review proceeding under the Sandia Health Plan for Retirees. The Claimant is required to pursue all administrative appeals described above as a precondition to challenging the denial of the claim in a lawsuit.

**Note:** The Claimant may not submit a dispute regarding eligibility to a court with respect to a denied claim under the Sandia Health Plan for Retirees more than one hundred eighty (180) days after the date that Via Benefits renders its final decision upon appeal.

Sandia Health Plan for Retirees dependent eligibility based on incapacitation is determined by the applicable medical and/or dental Claims Administrator. Contact Via Benefits at 888-598-7809 for information on applying for dependent incapacitation status.

### **Recovery of Excess Payment**

The Claims Administrator has the right at any time to recover any amount paid by a Sandia medical or dental Program for covered charges in excess of the covered benefits under the medical or dental Program provisions. In addition, Via Benefits has the right at any time to recover premiums paid for the Sandia-sponsored Medicare Advantage plans or YSA dollars. Payments may be recovered from covered members, providers of service, and other medical care plans.

**IMPORTANT:** By accepting benefits under the Sandia Health Plan for Retirees, the covered member agrees to reimburse payments made in error and cooperate in the recovery of excess payments.

## Section 11. When Coverage Ends

This section outlines when coverage ends for Retirees, Surviving Spouses, Long-Term Disability Terminees, Class I, and Class II Dependents. See [Section 12: Continuation of Group Health Coverage](#) for specific rules governing how health coverage may be continued for the above-referenced groups.

### Retirees

Medical or dental benefits for Retirees end:

- On the date the medical and/or dental benefits are terminated.
- On the last day of the month if payment is not received by Via Benefits within 60 calendar days of the due date on the bill (if applicable). Note: YSA reimbursement subsidy will end on the first day of the month of loss of qualification.
- On the date of death of the Retiree.
- Immediately upon determination of the submission of a fraudulent claim.
- Immediately upon termination for cause.

### Surviving Spouses

Medical benefits for Surviving Spouses end:

- On the date the medical benefits are terminated.
- If the Surviving Spouse marries.
- On the date of death of a Surviving Spouse.
- On the last day of the month if payment is not received by Via Benefits within 60 calendar days of the due date on the bill (if applicable).  
**Note:** YSA reimbursement subsidy will end on the first day of the month of loss of qualification.
- Immediately upon determination of the submission of a fraudulent claim.
- Immediately upon termination for cause.

Dental benefits for Surviving Spouse end when the retiree or employee is deceased.

### Long-Term Disability Terminees

Medical benefits for Long-Term Disability Terminees end:

- On the date the medical benefits are terminated.
- On the last day of the month in which you recover and the Plan benefit ceases.
- On the date of death of a Long-Term Disability Terminnee.

- On the last day of the month in which you become ineligible for LTD benefits, or LTD benefits end.
- On the last day of the month in which you stopped receiving a monthly LTD Benefit because you accepted a lump-sum disability payout.
- On the last day of the month if payment is not received by Via Benefits within 60 calendar days of the due date on the bill (if applicable). Note: YSA reimbursement subsidy will end on the first day of the month of loss of qualification.
- Immediately upon determination of the submission of a fraudulent claim.
- Immediately upon termination for cause.

## **Class I and Class II Dependents**

Medical and/or dental benefits for dependents end on the:

- Last day of the month in which the dependent becomes eligible for coverage as an employee under any Sandia medical or dental Program.
- On the last day of the month if payment is not received by Via Benefits within 60 calendar days of the due date on the bill (if applicable). Note: YSA reimbursement subsidy will end on the first day of the month of loss of qualification.
- Date the Retiree's, Surviving Spouse's, or Long-Term Disability Terminee's coverage ends.
- Last day of the month in which the dependent becomes ineligible for coverage under the applicable health benefits Program (refer to [Events Causing Your Dependent to Become Ineligible](#)).
- Last day of the month in which the Retiree, Surviving Spouse, or Long-Term Disability terminates (disenrolls) dependent coverage.
- Date of death of the dependent.
- Immediately upon submission of a fraudulent claim.
- Failure to provide eligibility documentation as described in Dependent Eligibility section (refer to [Proof of Dependent Status](#)).
- Immediately upon termination for cause.

**Note:** You must disenroll your dependents within 31 calendar days of the date your dependent becomes ineligible for coverage under the applicable Sandia medical or dental Program.

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

Sandia 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 under the self-funded medical and dental plans of a member may include any of the following:

- Permitting an unauthorized person to use your medical or dental identification card (unless you notified the Claims Administrator to report that your card was lost or stolen).
- Abuse of medical or dental coverage by providing false information on applications or forms.
- Verbal or physical threats to the Claims Administrator's employees, physician, or network provider.
- Fraudulent receipt of medical or dental services under the applicable Sandia medical or dental Program for noncovered persons.
- Failure to comply with subrogation and reimbursement rules.

The Sandia-sponsored Medicare Advantage Programs may terminate a member's coverage for cause, immediately by sending written notice to the member. Termination will be effective on the date the Sandia-sponsored Medicare Advantage Programs sent the notice. Refer to the Sandia-sponsored Medicare Advantage Programs Evidence of Coverage for definitions on what constitutes cause. You can obtain a copy of the Evidence of Coverage at [hr.sandia.gov](http://hr.sandia.gov) or by calling Via Benefits at 888-598-7809.

## Section 12. Continuation of Group Health Coverage

This section outlines the continuation of group health care coverage under COBRA in the event where you lose coverage under certain circumstances.

COBRA does not apply to the individual Medicare plans through the YSA Program; however, the dollar amounts in the YSA are subject to COBRA.

**IMPORTANT:** As an alternative to electing coverage under the Retiree Medical Plan Option (for medical and dental coverage), the Surviving Spouse Medical Plan Option (for medical coverage) or the Long-Term Disability Terminatee Medical Plan Option (for medical coverage), you may elect to temporarily continue the same coverage you currently have by making an election under COBRA. If you elect COBRA coverage instead of coverage under the Option listed above, you cannot elect the applicable Option after your COBRA coverage has terminated. If you elect the Retiree Medical Plan Option, the Surviving Spouse Medical Plan Option, or the Long-Term Disability Terminatee Medical Plan Option, you waive your rights to COBRA as it is an either/or option.

### Coverage through COBRA

On April 7, 1986, Congress passed a new law, the Consolidated Omnibus Budget Reconciliation Act (COBRA), requiring that most employers sponsoring group health plans offer the opportunity for a temporary extension of health coverage (called COBRA continuation coverage) at group rates in certain instances where coverage under your medical (including the health reimbursement account (HRA) for PreMedicare and the YSA for Medicare, and/or dental and/or vision Program would otherwise end.

COBRA continuation coverage is a continuation of health coverage when coverage would otherwise end because of a life event known as a Qualifying Event. See Qualifying Events Causing Loss of Coverage below. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. A qualified beneficiary includes:

- You,
- Your Spouse,
- Your dependent child,
- A dependent child who is enrolled pursuant to a qualified medical child support order (QMCSO),
- An eligible dependent child who is born to or placed for adoption with you during a period of COBRA continuation coverage.

Although Class II Dependents cannot be qualified beneficiaries within the meaning of federal law, Sandia currently offers COBRA-like continuation coverage to these individuals if they were covered under the medical Program when group coverage otherwise would have been lost. In

this description of COBRA, the term dependent child generally includes a Class II Dependent, and COBRA continuation coverage generally includes COBRA-like continuation coverage for Class II Dependents. COBRA qualified beneficiaries may temporarily continue coverage through Sandia by notifying Via Benefits of a Qualifying Event (divorce, legal separation, annulment, loss of dependent status). COBRA coverage will continue for qualified beneficiaries who pay the applicable COBRA rate, plus a two percent administrative fee, in a timely manner. If COBRA continuation coverage is not elected, all coverage under the Sandia Health Plan for Retirees will end.

As a qualified beneficiary, Sandia is required to provide coverage which is identical to the coverage provided under the Programs provided to similarly situated individuals. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Retirees or Long-Term Disability Terminees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect coverage on behalf of their children. Any changes made to the Sandia Health Plan for Retirees' terms that apply to similarly situated individuals will also apply to qualified beneficiaries receiving COBRA continuation coverage.

If you have questions about COBRA, contact Sandia Human Resources Customer Service at 505-844-4237.

### **Maximum HRA (PreMedicare)/Your Spending Arrangement (YSA) (Medicare) Benefit**

If a PreMedicare Retiree is enrolled in the Sandia Total Health Program and experiences a COBRA Qualifying Event (as indicated in the table), the maximum HRA benefit equals the HRA balance as of the COBRA event date. Generally, the maximum HRA benefit is applied to the qualified beneficiaries of the Retiree in aggregate. For example, if a Retiree gets divorced and also has a stepchild covered, and the Spouse elects COBRA for herself and child, and there is a maximum HRA benefit of \$2,000, the \$2,000 is applied to the Spouse and child. However, each qualified beneficiary does have the right to independently elect COBRA coverage and, therefore, would be entitled to the maximum HRA benefit; and as a result of some Qualifying Events (child aging out), some family members may retain Retiree coverage while others will be qualified beneficiaries. In such events, the qualified beneficiary would be entitled to the maximum HRA benefit.

If a Medicare Retiree is enrolled in the YSA Program and experiences a COBRA Qualifying Event (as indicated in the table), the maximum YSA benefit equals the YSA balance as of the COBRA event date. Generally, the maximum YSA benefit is applied to the qualified beneficiaries of the Retiree in aggregate. For example, if a Retiree gets divorced and also has a Medicare stepchild covered, and the Spouse elects COBRA for herself and child, and there is a maximum YSA benefit of \$2,000, the \$2,000 is applied to the Spouse and child. However, each qualified beneficiary does have the right to independently elect COBRA coverage and, therefore, would be entitled to the maximum YSA benefit; and as a result of some Qualifying Events (child aging out), some family members may retain Retiree coverage while others will be qualified beneficiaries. In such events, the qualified beneficiary would be entitled to the maximum YSA benefit.



## Qualifying Events Causing Loss of Coverage

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

Qualified beneficiary if you are the...	And if you, a covered member, lose medical or dental coverage due to...	Maximum period of continuation coverage is...
Spouse Children	Divorce or legal separation of the Spouse from the covered Retiree or Long-Term Disability Terminee Death of the covered Retiree or Long-Term Disability Terminee	36 months
Children	Loss of dependent status as referenced in <a href="#">Section 4: Eligibility Information</a>	36 months
See <a href="#">Disability Extension and Multiple Qualifying Events</a> below for more information.		

## Notification of Election of COBRA

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

Step	Who	Action
1	Retiree, Long-Term Disability Terminee, Surviving Spouse or family member	<p>Notify Extend Health, in writing, within 60 days from the end of the month in which the following occurs:</p> <ul style="list-style-type: none"> <li>• Divorce</li> <li>• Legal separation</li> <li>• Annulment</li> <li>• Loss of a child's dependent status</li> </ul> <p>Send notice to:  <b>Via Benefits/Mercer            Customer Service            P.O. Box 14464            Des Moines, IA 50306-3464</b></p> <p>In addition, you must provide documentation supporting the occurrence of the Qualifying Event, if Via Benefits requests it. Acceptable documentation includes a copy of the divorce decree or dependent child(ren)'s birth certificate(s), driver's license, or marriage certificate.</p> <p>If the above procedures are not followed or if the notice is not provided to Via Benefits within the 60-day notice period (which is the date of the event or from the end of the month in which the coverage would have been lost, whichever is later), you will lose your right to elect COBRA continuation coverage. In addition, if any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the Qualifying Event, you will be required to reimburse the Plan for any claims mistakenly paid.</p>
2	COBRA Administrator	COBRA Administrator will send you the notice of opportunity to elect temporary continued coverage. If the qualified beneficiary does not receive this notice, the qualified beneficiary should contact Via Benefits at 888-598-7809.

Step	Who	Action
3	Qualified Beneficiary	<p>Qualified beneficiary has 60 days from the later of the date you are furnished the COBRA eligibility notice or the date you would lose coverage.</p> <p>If you return your election form waiving your rights to COBRA continuation coverage and change your mind within the 60-day election period, you may revoke your waiver and still elect COBRA continuation coverage as long as it is within the original 60-day election period. However, you COBRA continuation coverage will be effective as of the date you revoked your waiver coverage.</p> <p>Qualified beneficiary must make initial premium payment within 45 days from the COBRA election date. You are allowed a 30-day grace period for monthly premium payment thereafter.</p> <p>If you elect to continue, Sandia provides coverage under the applicable medical or dental Program, at your expense, plus the applicable administrative fee.</p> <p>If you do not elect to continue coverage during the 60-day election period, coverage through Sandia ends at the end of the month in which the event occurred and the qualified beneficiary became ineligible for coverage.</p> <p>Failure to make any payment within the payment date requirement described above will cause you to lose all COBRA rights.</p> <p>Following the initial payment, if you do not pay a premium by the first day of a period of coverage, the COBRA Administrator has the option to cancel your 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.</p> <p>If the amount of payment is wrong, but is not significantly less than the amount due, the COBRA Administrator will notify you of the deficiency and grant a period of no longer than 30 days to pay the difference. The COBRA Administrator is not obligated to send monthly premium notices.</p>

## Termination of COBRA

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

- Premiums are not paid in full on a timely basis,
- Sandia and its entire control group cease 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 pre-existing condition of the qualified beneficiary,
- A qualified beneficiary becomes covered by Medicare (in which case the non-Medicare dependents have the right to continue their coverage for the remainder of the continuation time period), or
- A qualified beneficiary engages in conduct that would justify the Sandia Health Plan for Retirees in terminating coverage of a similar situated individual not receiving continuation coverage (such as fraud).

## **Disability Extension and Multiple Qualifying Events**

COBRA coverage may be extended under the following circumstances:

- If a qualified beneficiary is Social Security disabled 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 date. After the first 18 months of COBRA coverage, he/she will be charged 150% of the cost of the applicable group rate (102% for Kaiser).
- The individual must provide a copy of the Social Security disability determination to the COBRA Administrator 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.

## **Contact Information**

If you have any questions about COBRA continuation coverage or the application of the law, contact Sandia HR Customer Service at 505-844-4237, option 2.

You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

## **Section 13. Your Rights under ERISA**

As a participant in the self-funded programs and the YSA Program under the Sandia Health Plan for Retirees, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

### **Receive Information about Your Plan and Benefits**

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### **Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents governing the plan or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court, after exhausting the plan's claims and appeals procedures. In addition,

if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a Federal court, after exhausting the plan's claims and appeals procedures.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

### **Assistance with Your Questions**

If you have any questions about your plan, you should contact the Plan Administrator listed in [Appendix C: Plan Administration Information](#). If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## Section 14. Definitions

Please note that certain capitalized words in this SPD have special meanings. These words have been defined in this section. You can refer to this section as you read this document to have a clearer understanding of your benefits.

<b>Adverse Decision/Adverse Benefit</b>	A denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a benefit. An Adverse Benefit determination includes a decision to deny benefits based on: <ul style="list-style-type: none"> <li>• An individual being ineligible to participate in the Plan;</li> <li>• Utilization review;</li> <li>• A service being characterized as experimental or investigational or not medically necessary or appropriate;</li> <li>• A concurrent care decision; and</li> <li>• For medical claims, certain retroactive terminations of coverage, whether or not there is an adverse effect on any particular benefit at that time.</li> </ul>
<b>Class II Dependent</b>	See <a href="#">Section 4: Eligibility Information</a> .
<b>Dual Sandian</b>	Both Spouses are employed by or retired from Sandia.
<b>HMO</b>	Health Maintenance Organization
<b>Long-Term Disability Terminee</b>	A former 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.
<b>Medicare Eligible</b>	A member who is eligible for Medicare Parts A and B, whether they have enrolled in Medicare or not.
<b>Non-Qualifying Dependent</b>	A dependent who does not meet the definition of a qualifying child or qualifying relative under Internal Revenue Service Publication 502.
<b>PreMedicare</b>	An individual who is not yet eligible for Medicare.
<b>Primary Covered Member</b>	The person for whom the coverage is issued; that is, the Sandia Retiree, survivor, Long-Term Disability Terminee, or the individual who is purchasing temporary continued coverage.
<b>Primary Coverage</b>	The health plan that has the legal obligation to pay first when more than one health plan is involved.
<b>Qualifying Event</b>	Under COBRA, an event that but for the COBRA requirements would result in the loss of coverage to a qualified beneficiary.
<b>PSP</b>	Pension Security Plan
<b>Post-Medicare</b>	An individual who is eligible for Medicare.
<b>Qualified Medical Child Support Order (QMCSO)</b>	See <a href="#">Section 4: Eligibility Information</a> .
<b>Rehire</b>	Refer to <a href="#">Retirement Income Summary Plan Description</a> or <a href="#">Pension Security Plan Summary Plan Description</a> .
<b>Retiree</b>	See <a href="#">Section 4: Eligibility Information</a> .
<b>RIP</b>	Retiree Income Plan

<b>Service Area</b>	The geographical or other area to which a benefit program is limited, within which participating providers are accessible to members. For example, an HMO Service Area.
<b>Spouse</b>	Your lawful husband or wife as defined by federal law. This includes same gender spouses that were legally married in a jurisdiction that recognizes same gender marriages.
<b>Surviving Spouse/Surviving Dependents</b>	An enrolled Spouse or enrolled dependent of an on-roll regular employee or a Sandia Retiree who dies while covered under one of the medical Programs.

# Appendix A. Claims and Appeals Administrative Information

Send all claims and claim appeals for benefits to the Claims Administrator as outlined in this Section. As the claims fiduciary, determinations by the Claims Administrator shall be conclusive and not subject to review by Sandia.

Program	Group Number	Claims Administrator
Sandia Total Health Program (administered by UnitedHealthcare (UHC))	708576	<p><b>UHC Claims Address:</b>            UnitedHealthcare            P.O. Box 740809            Atlanta, GA 30374-0809</p> <p><b>UHC Appeals Address:</b>            UnitedHealthcare – Appeals            P.O. Box 30432            Salt Lake City, UT 84130-0432            877-835-9855  <a href="http://www.myuhc.com">www.myuhc.com</a></p> <p><b>Express Scripts Claims Address:</b>            Express Scripts            ATTN: Direct Claims            P.O. Box 2824            Clinton, IA 52733-2824</p> <p><b>Express Scripts Appeals Address:</b>  <b>Clinical appeal requests:</b>            Express Scripts            Attn: Clinical Appeals Department            PO Box 66588            St Louis, MO 63166-6588. Fax 877-852-4070</p> <p><b>Administrative appeal requests:</b>            Express Scripts            Attn: Administrative Appeals Department            PO Box 66587            St Louis, MO 63166-6587            Fax: 877-328-9660</p>



Program	Group Number	Claims Administrator
<p>Sandia Total Health Program (administered by Blue Cross and Blue Shield of New Mexico (BCBSNM))</p>	<p>N13958</p>	<p><b>BCBSNM Medical Claims Address:</b>            BCBSNM            P.O. Box 27630            Albuquerque, NM 87125-7630</p> <p><b>BCBSNM Behavioral Health Claims Address:</b>            BCBSNM Behavioral Health            P.O. Box 92165            Albuquerque, NM 87199-2165</p> <p><b>BCBSNM Medical and Behavioral Health Appeals Address:</b>            BCBSNM Appeals Unit            P.O. Box 27630            Albuquerque, NM 87125-9815            Phone: 800-205-9926            Fax: 800-773-1521  <a href="http://www.bcbsnm.com/sandia">www.bcbsnm.com/sandia</a></p> <p><b>Express Scripts Claims Address:</b>            Express Scripts            ATTN: Direct Claims            P.O. Box 2824            Clinton, IA 52733-2824</p> <p><b>Express Scripts Appeals Address:</b>  <b>Clinical appeal requests:</b>            Express Scripts            Attn: Clinical Appeals Department            PO Box 66588            St Louis, MO 63166-6588. Fax: 877-852-4070</p> <p><b>Administrative appeal requests:</b>            Express Scripts            Attn: Administrative Appeals Department            PO Box 66587            St Louis, MO 63166-6587            Fax: 877-328-9660</p>
<p>Sandia Total Health Program (administered by Kaiser Permanente of Northern California) (CA)</p>	<p>00110004</p>	<p><b>Medical Claims Address:</b>            Kaiser Permanente Insurance Company            Self-funded claims administrator            P.O. Box 30547            Salt Lake City, UT 84130-0547</p> <p><b>Rx Drug Claims Address:</b>            Optum Rx            P.O. Box 29044            Hot Springs, AR 71903</p> <p><b>Appeals Address:</b>            KPIC Appeals            3701 Boardman – Canfield R.            Canfield, Ohio 44406  <a href="http://www.kp.org">www.kp.org</a></p>

<b>Program</b>	<b>Group Number</b>	<b>Claims Administrator</b>
Kaiser Senior Advantage Plan	7455	<p><b>Claims Address:</b>  Kaiser Foundation Health Plan, Inc.  Claims Department  P.O. Box 24010  Oakland, CA 94623-1010</p> <p>Standard Appeals  Write to the Kaiser appeal address provided on the claim denial notification.</p> <p><b>Expedited Appeals Address:</b>  Kaiser Foundation Health Plan, Inc.  Expedited Review Unit  P.O. Box 23170  Oakland, CA 94623-0170</p>
Humana Medicare Employer HMO Plan	N/A	<p><b>Humana Health Plan, Inc.</b>  500 W Main Street  Louisville, KY 40202-2946</p>
UnitedHealthcare Group Medicare Advantage PPO Plan	13652	<p><b>Medical Claims Address:</b>  P.O. Box 30995  Salt Lake City, UT 84130-0995</p> <p><b>Prescription Drug Claims</b>  Optum Rx  P.O. Box 29045  Hot Springs, AR 71903</p> <p><b>Medical Appeals Address:</b>  UnitedHealthcare Group Medicare Advantage PPO Plan  Attn: Appeals &amp; Grievances Department  PO Box 6106, MS CA124-0157  Cypress, CA 90630</p> <p><b>Prescription Drug Appeals Address:</b>  Part D Appeals &amp; Grievance Department  PO Box 6106, MS CA 124-0197  Cypress, CA 90630-9948  Fax: 866-308-6296  Phone: 800-595-9532</p>
Your Spending Arrangement (YSA) Program	5780	<p><b>Claims Address:</b>  Via Benefits YSA  P.O. Box 3039  Omaha, NE 68103-3039</p> <p><b>Appeals Address:</b>  Via Benefits YSA  P.O. Box 3039  Omaha, NE 68103-3039</p>

Program	Group Number	Claims Administrator
Dental Care Program	8550	<p><b>Claims Address:</b>  Delta Dental of New Mexico  2500 Louisiana Blvd. NE, Suite 600  Albuquerque, NM 87110</p> <p><b>Appeals Address:</b>  Claims Administrator  Delta Dental of New Mexico  2500 Louisiana Blvd. NE, Suite 600  Albuquerque, NM 87110  800-264-2818  <a href="http://www.deltadentalnm.com/">http://www.deltadentalnm.com/</a></p>

## Appendix B. Funding and Contract Administration Information

Program	Contract Address	Insured/Self-Insured
Sandia Total Health Program (administered by UnitedHealthcare)	UnitedHealthcare 425 Market St. San Francisco, CA 94105-2483	Self-Insured
Sandia Total Health Program (administered by Blue Cross and Blue Shield of New Mexico for medical)	Blue Cross Blue Shield of New Mexico 5701 Balloon Fiesta Parkway NE Albuquerque, NM 8787113	Self-Insured
Sandia Total Health Program (administered by Kaiser Permanente of Northern California) (CA)	Kaiser Permanente Insurance Company 300 Lakeside Drive 26th Floor Oakland, CA 94612	Self-Insured
Kaiser Senior Advantage Plan	Kaiser Foundation Health Plan, Inc. 1350 Treat Boulevard Walnut Creek, CA 94596-2174	Insured Medicare Advantage Plan
Humana Medicare Employer HMO Plan	Humana Health Plan, Inc. 500 W Main Street Louisville, KY 40202-2946	Insured Medicare Advantage Plan
UnitedHealthcare Group Medicare Advantage PPO Plan	UnitedHealthcare Services Inc 9900 Bren Rd E Minnetonka, MN 55343	Insured Medicare Advantage Plan
Your Spending Arrangement (YSA) Program	Via Benefits 10975 Sterling View Drive Suite A1 South Jordan, UT 84095	Self-insured
Dental Care Program	Delta Dental of New Mexico 2500 Louisiana Blvd. N.E. Suite 600 Albuquerque, NM 87110	Self-Insured

## Appendix C. Plan Administration Information

What	Who
Official Plan Name	Sandia Health Plan for Retirees (Refer to Appendix B, Funding and Contract Administrative Information for a listing of Benefit Programs applicable to this SPD)
Employer/Plan Sponsor	National Technology & Engineering Solutions of Sandia ("NTESS"), LLC 1515 Eubank S.E. Albuquerque, NM 87123
Employer I.D. Number (EIN)	85-0097942
Plan Number	545
Type of Plan	The Sandia Health Plan for Retirees is a welfare benefit plan which includes medical and dental benefits.
Plan Funding Medium	The insurance arrangements are paid by insurance policies. The benefits and other costs (such as administrative costs) for the self-funded programs are paid from the general assets of National Technology & Engineering Solutions of Sandia ("NTESS"), LLC
Plan Administrator	Sandia Health Plans Team Physical address: Building 832 Room 40 Frost Street Kirtland Air Force Base Albuquerque, NM Mailing address: 1515 Eubank S.E. Albuquerque, NM 87123-1022 OR P.O. Box 5800 Albuquerque, NM 87185-1022 505-844-4237, option 2
Claims Administrator	Refer to <a href="#">Appendix A: Claims and Appeals Administrative Information</a>
Agent for Service of Legal Process	Corporation Service Company (CSC) 2711 Centerville Road, Suite 400 Wilmington, DE 19808 OR 123 Easy Marcy Street, Suite 101 Santa Fe, NM 87501 OR 2730 Gateway Oaks Drive, #100 Sacramento, CA 95833
Plan Year	January 1 – December 31
Contribution Sources	National Technology & Engineering Solutions of Sandia ("NTESS"), LLC and participant contributions

## **Appendix D. HIPAA Privacy Practices**

### **SANDIA NATIONAL LABORATORIES HEALTH PLANS NOTICE OF PRIVACY PRACTICES**

**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.**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as protected health information (PHI), includes virtually all individually identifiable health information held by the plan – whether received in writing, in an electronic medium, or as an oral communication.

This Notice of Privacy Practices (the “Notice”) describes the privacy practices of the Sandia Health Benefits Plan for Employees and its component self-insured benefit Programs to include the Sandia Total Health Programs; Dental Care Program; Vision Care Program; and the Sandia On-Site Clinic Program as well as the Sandia Health Benefits Plan for Retirees and its component self-insured benefit Programs to include the Sandia Total Health Programs; Kaiser Senior Advantage Plan, Humana Medicare Employer HMO Plan, and UnitedHealthcare Group Medicare Advantage PPO Plan. In addition, it also describes the privacy practices of the Sandia Flexible Spending Accounts Plan (Healthcare Flexible Spending Account only).

The Sandia Health Benefits Plan for Employees, and its component self-insured benefit Programs, the Sandia Health Benefits Plan for Retirees, and its component self-insured benefit Programs, and the Sandia Flexible Spending Accounts Plan (Healthcare Flexible Spending Account only) covered by this Notice may share health information with each other to carry out treatment, payment, or health care operations. Under HIPAA, these plans are collectively known as an Organized Health Care Arrangement. For the purposes of this Notice, unless otherwise specified, they are referred to as the Plan. If you participate in an insured plan option (Kaiser Senior Advantage Plan, Humana Medicare Employer HMO Plan, UnitedHealthcare Group Medicare Advantage PPO Plan, or an individual Medicare plan through YSA, you will receive any Notices directly from the insurer.

### **Changes to the Information in this Notice**

The Plan must abide by the terms of the privacy Notice currently in effect. This Notice took effect on April 14, 2003 and has been updated effective January 1, 2019. However, the Plan reserves the right to change the terms of its privacy policies as described in this Notice at any time, and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If material changes are made to the Plan’s privacy policies described in this Notice, you will be provided with a revised privacy Notice.

## The Plan's Duties with Respect to Health Information about You

The Plan is required by law to maintain the privacy of your health information and to provide you with this Notice of the Plan's legal duties and privacy practices with respect to your health information. It's important to note that these rules apply to the Plan, not NTESS as an employer – that's the way the HIPAA rules work. Different policies may apply to other NTESS programs or to data unrelated to the health plan.

## Uses and Disclosures of Medical Information without Your Written Authorization

Under the law, the Plan may use or disclose your protected health information under certain circumstances without your permission. The term "protected health information" or "PHI" includes all individually identifiable health information related to your past, present or future physical or mental health condition or to payment for health care. The term also includes genetic information (such as family medical history and information about an individual's receipt of genetic services or tests). PHI includes information maintained by the Plan in oral, written, or electronic form.

The following categories describe the different ways that the Plan may use and disclose your protected health information. However, not every use or disclosure is listed.

- **Treatment.** The Plan may use or disclose your protected health information which can include facilitating medical treatment or services by providers. *For example, the Plan may share your protected health information with a pharmacist if a question arises as to whether there might be a contraindication for a newly prescribed medication.*
- **Payment.** The Plan may use or disclose your protected health information which can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing. *For example, the Plan may share your protected health information with another health plan in order to coordinate payment of benefits.*
- **Health care operations.** The Plan may use or disclose your protected health information which can include activities by this Plan (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. *For example, the Plan may use information about your claims to project future benefit costs.*
- **Business Associates.** The Plan may disclose your medical information to its Business Associates to perform various functions on the Plan's behalf. In order to perform these functions, Business Associates may receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with the Plan to implement appropriate safeguards regarding your protected health information. *For example, the Plan may disclose your protected health information to a Business Associate to administer claims. All Business Associates are directly subject to certain*

provisions of the HIPAA Privacy Rule and all provisions of the Security Rule, and must, therefore, comply with such legal requirements and with their contractual obligations set forth under the Business Associate Agreement with the Plan.

The amount of health information used or disclosed will be limited to the minimum necessary for these purposes. The Plan may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

In addition, any information provided in the Health Assessment is held in confidence by the Virgin Pulse and otherwise is used only in an aggregate, anonymous form in reporting or for scientific research.

### ***The Plan may share your health information with Sandia***

The Plan may disclose your health information **without** your written authorization to NTESS for plan administration purposes, including eligibility and Sandia Onsite Clinic Program appeals. NTESS agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law.

Here's how health information may also be shared between the Plan and the insurers and NTESS, as allowed under the HIPAA rules:

- The Plan may disclose "summary health information" to NTESS if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, but from which names and other identifying information has been removed.
- The Plan may disclose to NTESS information on whether an individual is participating in the Plan, or has enrolled or disenrolled in an insurance option offered by the Plan.

In addition, you should know that NTESS cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by NTESS from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act, or worker's compensation is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).

### ***Other allowable uses or disclosures of your health information***

In certain cases, your health information can be disclosed **without** authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made, for example, if you're not present or if you're incapacitated). If you are not present, or the opportunity to agree or object cannot practicably be provided, we may exercise our professional judgment and determine that it is in your best interest to disclose your protected health information. In addition, your health information may be disclosed without authorization to your legal representative.



The Sandia Onsite Clinic Program may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

The Plan is also allowed to use or disclose your health information **without** your written authorization for the following activities:

<b>Worker's compensation</b>	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with such laws
<b>Necessary to prevent serious threat to health or safety</b>	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (including disclosures to the target of the threat); includes disclosures to assist law enforcement officials in identifying or apprehending an individual because the individual has made a statement admitting participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
<b>Public health activities</b>	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
<b>Victims of abuse, neglect, or domestic violence</b>	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
<b>Judicial and administrative proceedings</b>	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request, or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
<b>Law enforcement purposes</b>	Disclosures to law enforcement officials required by law or pursuant to legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises
<b>Decedents</b>	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
<b>Organ, eye, or tissue donation</b>	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death

<b>Research purposes</b>	Disclosures subject to approval by institutional or private privacy review boards, and subject to certain assurances and representations by researchers regarding necessity of using your health information and treatment of the information during a research project
<b>Health oversight activities</b>	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
<b>Specialized government actions</b>	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
<b>HHS investigations</b>	Disclosures of your health information to the Department of Health and Human Services (HHS) to investigate or determine the Plan's compliance with the HIPAA privacy rule

## **Uses and Disclosures of Medical Information with Your Written Authorization**

Except as described in this Notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization in writing as allowed under the HIPAA rules; however, you can't revoke your authorization if the Plan has taken action relying on it. In other words, you can't revoke your authorization with respect to disclosures the Plan has already made.

### ***Your Individual Rights***

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the Notice describes how you may exercise each individual right. See the information at the end of this Notice on how to submit requests.

Note about Personal Representatives: Parents and guardians will generally have the right to control the privacy of protected health information about minors unless the minors are permitted by law to act on their own behalf. If, under applicable law, a parent, guardian, or other person has the authority to act on behalf of an individual who is an unemancipated minor in making decisions related to health care, we will treat that person as a personal representative with respect to certain protected health information. If, under applicable law, a person has the authority to act on behalf of an individual who is an adult or an emancipated minor in making decisions related to health care, we will treat that person as a personal representative with respect to certain protected health information.

***Right to request restrictions on certain uses and disclosures of your health information and the Plan’s right to refuse***

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death – or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, you must make this request to the Plan in writing.

This Plan is not required to agree to a requested restriction. And if the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you’re notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

***Right to receive confidential communications of your health information***

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, you must make this request to the Plan in writing and the request must include a statement that disclosure of all or part of the information could endanger you.

***Right to inspect and copy your health information***

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a “designated record set.” This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do **not** have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, you must make this request to the Plan in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the Plan will provide you with:

- The access or copies requested;
- A written denial that explains why the request was denied and any rights you may have to have the denial reviewed or file a complaint; or

- A written statement that the time period for reviewing the request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address the request.

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan may also charge reasonable fees for copies or postage.

If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

***Right to amend your health information that is inaccurate or incomplete***

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, the request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, you must make this request to the Plan in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of the request, the Plan will:

- Make the amendment as requested;
- Provide a written denial that explains why the request was denied and any rights you may have to disagree or file a complaint; or
- Provide a written statement that the time period for reviewing the request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address the request.

***Right to receive an accounting of disclosures of your health information***

You have the right to a list of certain disclosures the Plan has made of your health information. This is often referred to as an "accounting of disclosures." You generally may receive an accounting of disclosures if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this Notice, unless otherwise indicated below.

You may receive information on disclosures of your health information going back for six years from the date of the request, but not earlier than April 14, 2003 (the general date that the HIPAA privacy rules are effective). You do **not** have a right to receive an accounting of any disclosures made:

- For treatment, payment, or healthcare operations;
- To you about your own health information;
- Incidental to other permitted or required disclosures;

- Where authorization was provided;
- To family members or friends involved in your care (where disclosure is permitted without authorization);
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- As part of a “limited data set” (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, you must make this request to the Plan in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address the request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You will be notified of the fee in advance and have the opportunity to change or revoke the request.

***Right to be notified of a breach***

You have the right to be notified in the event that the Plan or a Business Associate discovers a breach of unsecured protected health information. If health information that the Plan or any of its business associates uses or discloses is “breached” within the meaning of the notification requirements of the Privacy Rule, then, in accordance with HIPAA and the Plan’s policies and procedures, the Plan will provide the required notifications to those individuals who have been affected by the breach, the Department of Health and Human Services and to any other necessary parties.

***Right to obtain a paper copy of this Notice from the Plan upon request***

You have the right to obtain a paper copy of this privacy Notice upon request. Even individuals who agreed to receive this Notice electronically may request a paper copy at any time. To obtain a paper copy of this Notice, contact the Health Plans HIPAA Privacy Officer at 505-844-4237.

**Compliance with the Genetic Information Nondisclosure Act of 2008**

In accordance with federal law, the Plan does not intend to use or disclose genetic information for any underwriting purposes.

## **Complaints**

If you believe your privacy rights have been violated, you may complain to the Plan or the Secretary of the U.S. Department of Health and Human Services.

You may complain to the Plan in care of the following officer:

Health Plans HIPAA Privacy Officer  
Sandia National Laboratories  
P.O. Box 5800, Mail Stop 1022  
Albuquerque, NM 87185  
505-844-4237, option 2

You will not be retaliated against for filing a complaint.

## **Contacts**

If you have any questions regarding this Notice or the subjects addressed in it, or for more information on the Plan's privacy policies or your rights under HIPAA, please contact the following individual:

Health Plans HIPAA Privacy Officer  
Sandia National Laboratories  
P.O. Box 5800, MS-1022  
Albuquerque, New Mexico 87185-1022  
505-844-4237, option 2

### ***Contacts for Individual Rights***

To request restrictions on the use/disclosure of your health information, request that communications be handled in a different manner or sent to a different place (confidential communications), request access to or copies of your health information, request an amendment of your health information, and/or to request an accounting of disclosures for the different benefit programs/plans offered by NTESS , please contact the individual health plans directly as noted below.

<b>For questions relating to Sandia Total Health Medical:</b>	
Blue Cross Blue Shield of New Mexico	BCBSNM P.O. Box 27630 Albuquerque, NM 87125-7630 877-498-7652
Kaiser Permanente of Northern California	Lori Dutcher VP MSSA Compliance 3100 Thornton Avenue Burbank, CA 91504
UnitedHealthcare	UnitedHealthcare Customer Service Privacy Unit P.O. Box 740815 Atlanta, GA 30374-0815
<b>For questions relating to out-patient prescription drug coverage:</b>	
Express Scripts, Inc.	Express Scripts, Inc. P.O. Box 66561 St. Louis, MO 63166-6561 <a href="mailto:Privacy@express-scripts.com">Privacy@express-scripts.com</a>
<b>For questions relating to the Sandia Dental and Vision Care Programs:</b>	
Sandia Dental Care Program	Delta Dental of New Mexico 2500 Louisiana Blvd. NE Suite 600 Albuquerque, NM 87110 800-264-2818
Sandia Vision Care Program	Davis Vision Privacy Office P.O. Box 1416 Latham, NY 12110-1416 800-571-3366
<b>For questions relating to the Sandia Onsite Clinic Program</b>	
Sandia Onsite Clinic	Health Plans HIPAA Privacy Officer Sandia National Laboratories P.O. Box 5800, MS-1022 Albuquerque, NM 87185-1022 505-844-4237, option 2

## Appendix E. Program Summary Materials & Evidence of Coverage(s)

The following supplemental Benefit Program Materials, together with any updates (including any Summary of Material Modifications (SMMs) and open enrollment materials), are hereby incorporated by reference into the SPD and the Plan.

- [Sandia Total Health Program Summary \(administered by UnitedHealthcare\)](#)
- [Sandia Total Health Program Summary \(administered by Blue Cross and Blue Shield of New Mexico\)](#)
- [Sandia Total Health Program Summary \(administered by Kaiser Permanente of Northern California\)](#)
- [Your Spending Arrangement \(YSA\) Program Summary](#)
- [Dental Care Program Summary](#)
- [Kaiser Senior Advantage Plan – a Medicare Advantage Plan Evidence of Coverage](#)
- [Humana Medicare Employer HMO Plan –Evidence of Coverage](#)
- [UnitedHealthcare Group Medicare Advantage PPO Plan – a Medicare Advantage Plan- Evidence of Coverage](#)

All supplemental Benefit Program Materials are available at [hr.sandia.gov](http://hr.sandia.gov).