



Sandia National Laboratories



Sandia Total Health administered by UnitedHealthcare

(Employees, PreMedicare Retirees, Survivors, &
Long Term Disability (LTD) Terminees)

Revised: January 1, 2019

Program Summary

IMPORTANT

This Program Summary applies to all employees, PreMedicare retirees, survivors, and Long Term Disability (LTD) Terminees effective January 1, 2019.

For more information on other benefit programs, refer to the [National Technology & Engineering Solutions of Sandia, LLC. \("NTESS"\) Health Benefits Plan for Employees Summary Plan Description](#) or the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#).

The Sandia Total Health Program is maintained at the discretion of NTESS and is not intended to create a contract of employment and does not change the at will employment relationship between you and NTESS. The NTESS Board of Managers (or designated representative) reserve the right to amend (in writing) any or all provisions of the Sandia Total Health Program, and to terminate (in writing) the Sandia Total Health Program at any time without prior notice, subject to applicable collective bargaining agreements.

The Sandia Total Health Program's terms cannot be modified by written or oral statements to you from human resources representatives or other NTESS personnel.



U.S. DEPARTMENT OF
ENERGY



Sandia National Laboratories is a multimission laboratory managed and operated by National Technology & Engineering Solutions of Sandia, LLC., a wholly owned subsidiary of Honeywell International, Inc., for the U.S. Department of Energy's National Nuclear Security Administration under contract DE-NA0003525. SAND 2019-2426 O

Contents

Section 1. Introduction	1
Section 2. Summary of Changes	2
Section 3. Accessing Care	3
In-Network and Out-of-Network Options	3
Eligible Expenses	4
In-Network Benefits	4
Out-of-Network Benefits	4
Prior Authorization Requirements	5
Medical Services	6
Behavioral Health	7
Predetermination of Benefits	7
Non-Emergency or Non-Urgent Care Away from Home	8
Provider Networks	8
UnitedHealth Premium® Designation Program	9
Provider Directories	10
Provider Searches Online	10
Employee Assistance Program (EAP)	10
Precertification Requirements for EAP Services	11
Virtual Visits	11
Advocate4Me NurseLine	12
Telephone	12
Informational Recorded Messages	13
Live Nurse Chat	13
UnitedHealth Personal Health Support Program	13
Case Management Program	13
Disease Management Program	14
Centers of Excellence (formerly United Resource Networks (URN) Programs)	14
Transplant Resource Services Program (Organ and Tissue Transplantation)	16
Cancer Resource Services Program	17
Congenital Heart Disease Resource Services Program	17
Shared Savings Program	18
Healthcare Fraud Information	18
Section 4. Deductibles, Out-of-Pocket Limits and Lifetime Limits	20
Deductibles	20
Deductibles for Admissions Spanning Two Calendar Years	22
Coinsurance	22
Out-of-Pocket Limits	22
Medical Expenses Incurred through UnitedHealthcare	23
Prescription Drug Expenses Incurred through Express Scripts	25

Lifetime Limits	25
Section 5. Health Reimbursement Account.....	26
Health Reimbursement Account (HRA) Amounts.....	26
Annual Allocation of HRA Contributions	26
Events Resulting in Loss of HRA Funds	27
New Hires.....	28
Eligible Mid-Year Election Change Events	28
Open Enrollment Changes for Dual Sandians.....	28
What Healthcare Expenses are Eligible for HRA Reimbursement.....	29
How the HRA Works	29
Example 1.....	29
Example 2.....	31
UHC Healthcare Spending MasterCard	31
Claims Processing with an HCFSA and/or HRA	32
Medical Expenses.....	33
Prescription Drugs.....	34
Setting up Direct Deposit	34
Turning off the Auto-Rollover Feature	34
If you have an HRA	34
If you have both an HCFSA and HRA.....	35
Health Assessment and Biometric Screenings	35
Health Assessment Process	35
Biometric Screenings Process	36
Virgin Pulse Incentive Management Program	36
Health Action Plan	36
Tools and Resources to Become a More Informed Consumer.....	37
My UHC Website.....	37
Express Scripts Website	38
Section 6. Covered Medical Plan Services & Limitations.....	39
Program Highlights	39
Coverage Details	40
Acupuncture Services.....	40
Allergy Services	40
Ambulance Services.....	40
Auditory Integration Training	41
Behavioral Health Services	41
Special Mental Health Programs and Services	42
Cancer Services	43
Clinical Trials.....	44
Chiropractic Services	46
Dental Services.....	46

Diabetes Services/Devices/Supplies	47
Diagnostic Tests	48
Durable Medical Equipment (DME).....	48
Emergency Care	50
Employee Assistance Program (EAP).....	51
Eye Exam/Eyeglasses/Contact Lenses	52
Family Planning	52
Genetic Testing	52
Hearing Aids/Exam	52
Home Healthcare Services	53
Hospice Services	53
Infertility Services	53
Infusion Therapy	54
Injections in Physician’s Office	55
Inpatient Care	55
Maternity Services.....	55
Medical Supplies	57
Nutritional Counseling	57
Obesity Surgery	58
Office Visits	58
Organ Transplants	59
Outpatient Surgical Services	59
Prescription Drugs (other than those dispensed by Express Scripts)	60
Preventive Care	60
Professional Fees for Surgical Procedures	67
Prosthetic Devices/Appliances	68
Reconstructive Procedures	68
Rehabilitation Services (Outpatient Therapies)	69
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services.....	69
Temporomandibular Joint (TMJ) Syndrome.....	70
Urgent Care	70
Section 7. Prescription Drug Program.....	71
Eligibility.....	72
Covered Prescriptions.....	72
Covered Preventive Medications	73
National Preferred Formulary.....	75
Prescriptions Requiring Prior Authorization.....	76
Prescriptions Subject to Step Therapy Program.....	76
Smart90 Retail Program	77
Mail Service Program.....	77

Steps for Ordering and Receiving Mail Order Prescriptions (other than Specialty Medications).....	78
Brand-To-Generic Substitution.....	79
Retail Pharmacies.....	80
Using the Network Retail Pharmacies.....	80
Using the Out-of-Network Retail Pharmacies.....	80
Specialty Drug Management Program.....	80
Steps for Ordering and Receiving Specialty Prescriptions through Accredo:.....	81
Section 8. What’s Not Covered – Exclusions.....	82
Section 9. Coordination of Benefits (COB).....	89
Section 10. How to File a Claim.....	91
Filing an Initial Claim.....	91
In-Network Claims Processing.....	91
Out-of-Network Claims Processing.....	91
Benefits Payments.....	93
Recovery of Excess Payment.....	94
Section 11. How to File an Appeal.....	95
Filing an Appeal.....	95
UnitedHealthcare Appeals Process.....	97
Concurrent Care Claims.....	98
External Review Program.....	98
Standard External Review.....	99
Expedited External Review.....	100
Express Scripts Appeals Process.....	101
Section 12. Sandia Total Health Administrative Services.....	104
Claims Administrators.....	104
UHC Member Identification Cards.....	104
Express Scripts Member Identification Cards.....	104
My UHC Website.....	104
Express Scripts Website.....	105
Contact Telephone Numbers and Hours of Operation.....	106
When You Change Your Address.....	107
Section 13. Definitions.....	108
Section 14. UnitedHealth Allies Health Discount Program.....	114

Section 1. Introduction

This is a summary of highlights of the Sandia Total Health Program (“the Program”), a component of the National Technology & Engineering Solutions of Sandia, LLC. (“NTESS”) Health Benefits Plan for Employees (ERISA Plan 540) and the NTESS Health Benefits Plan for Retirees (ERISA Plan 545). This Program Summary is part of the [NTESS Health Benefits Plan for Employees Summary Plan Description](#) or the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#). It contains important information about your NTESS or “Sandia” healthcare benefits.

Certain capitalized words in this Program Summary have special meaning. These words have been defined in [Section 13: Definitions](#).

When the words “we”, “us”, and “our” are used in this document, we are referring to Sandia. When the words “you” and “your” are used throughout this document, we are referring to people who are Covered Members as defined in [Section 13: Definitions](#).

Many sections of this Program Summary are related to other sections of the Program Summary and to information contained in the [NTESS Health Benefits Plan for Employees Summary Plan Description](#) or the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#). You will not have all of the information you need by reading only one section of one booklet.

Refer to the [NTESS Health Benefits Plan for Employees Summary Plan Description](#) or the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#) for information about eligibility, enrollment, disenrollment, premiums, termination, coordination of benefits, subrogation and reimbursement rights, when coverage ends, continuation of coverage provisions, and your rights under the Employee Retirement Income Security Act of 1974 (ERISA) and the Affordable Care Act (ACA).

To receive a paper copy of this Program Summary, other Program Summaries, the [NTESS Health Benefits Plan for Employees Summary Plan Description](#) or the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#), contact HR Customer Service at 505-844-4237, option 2 or email hbesupport@mailps.custhelp.com. These documents are also available electronically at hr.sandia.gov.

Since these documents will continue to be updated, it is recommended to check back on a regular basis for the most recent version.

Section 2. Summary of Changes

The following changes are effective January 1, 2019:

- Virtual visits have a \$25 copay per visit, which is not subject to the deductible, but subject to the medical out of pocket maximum (tele-behavioral health visits follow the behavioral health benefit). For more information, see [Section 3: Accessing Care](#).
- Benefits for clinical trials have been updated. For more information, see [Section 6: Covered Medical Plan Services & Limitations](#).

The following are clarifications/reminders for 2019:

- Immunizations for personal travel will pay 80% of the Eligible Expenses in-network and 60% of the Eligible Expenses, after the deductible.
- The Health Reimbursement Account (HRA) claim filing period has changed. See [Section 5: Health Reimbursement Account](#) for more information.
- If you are a member who turned the pay the provider feature OFF or ON in the previous plan year, this feature no longer resets to the default (ON) at the beginning of every year. Therefore, you no longer have to update the feature for the current plan year. If you would like to make any future changes to this feature, visit www.myuhc.com.
- Qualified 213(d) expenses (which include eligible medical, dental, vision, and prescription expenses) incurred in the previous plan year cannot be paid with HRA funds that were earned for the current plan year.
 - Please remember to save all FSA and HRA claim receipts.
- In order to receive HRA funding for the following year:
 - **Active employees and their spouses** must complete the online Health Assessment by December 31st of the previous year by logging into Virgin Pulse. If the Health Assessment is completed by November 30 of the previous year, HRA funds will be received by January 1.
 - **PreMedicare retirees and their PreMedicare spouses, LTD Terminees and their spouses, and Surviving Spouses** must complete their Health Assessment through UHC from October 1 through September 30 (of the current year).
 - **PreMedicare retirees (and their spouses) that retired prior to September 30 of the current year** and completed the Health Assessment(s) prior to retirement through Sandia will need to complete a new Health Assessment through UHC by September 30 in order to receive funding.

Section 3. Accessing Care

This section describes how to access medical and behavioral healthcare under the in-network and out-of-network options, Prior Authorization requirements, predetermination of benefits, accessing non-Emergency or non-Urgent Care while away from home, the Employee Assistance Program, the UnitedHealthcare (UHC) and United Behavioral Health (UBH) provider networks, and other general information. For information on the Prescription Drug Program, refer to [Section 7: Prescription Drug Program](#).

In-Network and Out-of-Network Options

The Sandia Total Health Program provides both in-network and out-of-network benefits. You may select providers either in-network or out-of-network, however using your in-network benefit allows you to receive the maximum available benefit.

Note: You can use the in-network or out-of-network option at any time during the year, any time you need medical care.

The in-network option provides you access to physicians, facilities, and suppliers who are contracted with UHC/UBH contracted network to provide their services at negotiated fees. No referrals are required. Some procedures may require Prior Authorization or precertification (such as behavioral health services), which you are responsible for asking your physicians to obtain from UHC (refer to this section for more information). For the most updated in-network provider listings in your area, contact UHC Customer Service at 877-835-9855 or access the website at www.myuhc.com.

The advantages of using the in-network option include:

- Lower Coinsurance you will pay (e.g., 20% versus 40%)
- Lower Out-of-Pocket Limits (e.g., \$2,750 versus \$6,500 per person, which includes Deductibles)
- No responsibility for amounts exceeding Eligible Expenses
- Certain preventive care services covered at 100%
- Generally, no claims to file

The out-of-network option offers a lower level of benefit but enables you to get services from licensed providers outside the contracted network. No referrals are required. You are responsible for Deductibles, Coinsurance, and amounts exceeding Eligible Expenses. You are also responsible for filing all claims not filed by the provider and must obtain Prior Authorization or precertification (for behavioral health services) for all hospital care and certain medical care in order to be eligible for full benefits.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to out-of-network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in [Section 3: Accessing Care](#) for more information about how the Shared Savings Program applies.

If you are admitted to a hospital on an Emergency basis that is not in the network and services are covered, in-network benefits will be paid until you are stabilized. Once stabilized, you must be moved to a network hospital to continue in-network benefits. You may elect to remain in the out-of-network hospital and receive out-of-network benefits, as long as UHC confirms the treatment to be Medically Necessary.

Eligible Expenses

Sandia National Laboratories has delegated to UnitedHealthcare (UHC) the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UHC determines that will be paid for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UHC will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UHC's reimbursement policy guidelines, as described as below.

In-Network Benefits

In-network eligible expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are UHC's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UHC, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law. Emergency Services received out of network will be paid at the in-network benefit level subject to applicable Deductible and co-insurance.

Out-of-Network Benefits

Out-of-network eligible expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
 - Negotiated rates agreed to by the non-Network provider and either UHC or one of UHC's vendors, affiliates or subcontractors, at UHC's discretion.
 - If rates have not been negotiated, then one of the following amounts:

- For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
 - For Mental Health Services and Substance Use Disorder Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters' level counselor.
 - When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.
 - When a rate is not published by CMS for the service, UHC uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, UHC will use a comparable scale(s). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
- IMPORTANT NOTICE:** Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.
- When Covered Health Services are received from a Network provider, Eligible Expenses are UHC's contracted fee(s) with that provider.

Prior Authorization Requirements

When you choose to receive certain Covered Health Services (listed below), you are responsible for notifying Personal Health SupportSM before you receive these services, otherwise your benefits will be reduced. Personal Health SupportSM ensures you and/or your covered dependents receive the most appropriate and Cost-effective services available.

IMPORTANT: Just because a service or procedure does not require Prior Authorization does not mean that it is a covered benefit. In order to ensure that services and procedures are covered, you are encouraged to obtain a predetermination of benefits.

The first \$300 of covered charges will not be reimbursed if you, a family member, or your provider does not contact Personal Health SupportSM within the applicable time frames. An exception to this requirement would be, if you have primary healthcare coverage for these services under Medicare or another non-Sandia healthcare program.

You or your provider must notify Personal Health SupportSM for:

- Non-Emergency admissions: at least five business days before admission

- Emergency admissions: within two business days, or as soon as reasonably possible
- Other than admissions: at least five business days before receipt of services or purchase or rental of DME

IMPORTANT: Most of the time the provider will obtain Prior Authorization; however, it is ultimately your responsibility to call UHC at 877-835-9855 to initiate the review process. This is required for both in- or out-of-network facilities used by you or your covered dependent.

Medical Services

Medical services (whether in- or out-of-network) that require Personal Health SupportSM Prior Authorization:

- Air ambulance services
- Clinical trials
- Congenital Heart Disease services
- Dental services stemming from illness or injury
- Durable Medical Equipment with a purchase or cumulative rental value of \$1,000 or more
- External insulin pumps and continuous glucose monitoring systems, regardless of cost
- Genetic testing (including breast cancer genetic testing [BRACA])
- Home healthcare
- Hospice care
- Hospital inpatient stay, including Emergency admission
- Immunoglobulin infusion (IVIG) therapy
- Injectable outpatient chemotherapy
- Maternity care that exceeds the delivery time frames as described in [Section 6: Covered Medical Plan Services & Limitations](#). **Note:** if delivery is at home but requires admission to the hospital, notification is required.
- Obesity surgery
- Reconstructive procedures
- Surgery - only for the following outpatient surgeries: diagnostic catheterization and electrophysiology implant and sleep apnea surgeries
- Skilled Nursing Facility/inpatient rehabilitation facility services
- Sleep disorder studies

- Therapeutics - only for the following services: dialysis, intensity modulated radiation therapy, and MR-guided focused ultrasound.
- Transplantation Diagnostic cardiac catheterization, electrophysiology implant, and sleep apnea surgeries
- MR guided focused ultrasound

You are encouraged to notify Personal Health SupportSM prior to receiving the following services in order for Personal Health SupportSM to determine if they are Covered Health Services:

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

These services will not be covered when determined to be Cosmetic Procedures or not Medically Necessary and you may be responsible for the entire cost.

Behavioral Health

Mental health and Substance Abuse services (whether in- or out-of-network) that require Personal Health SupportSM Prior Authorization:

- Applied Behavioral Analysis (ABA) therapy for Autism Spectrum Disorders (ASD)
- Inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility)
- Intensive Outpatient Program treatment
- Outpatient electro-convulsive treatment
- Psychological testing

IMPORTANT: If you are planning on using an out-of-network provider for inpatient or Partial Hospitalization/Day treatments, Residential Treatment Facility, or Intensive Outpatient Program, remember that you must call UBH and get Prior Authorization. Please note that out-of-network providers for these services may require up-front payment and may not cooperate with UBH regarding the authorization process; therefore, you may not be able to receive benefits for these services.

Predetermination of Benefits

The Sandia Total Health Program covers a wide range of medical care treatments and procedures. However, medical treatments that are Investigational, Experimental, or Unproven to be medically effective are not covered by the Sandia Total Health Program. Contact UHC before incurring charges that may not be covered.

In addition, some services may be covered only under certain circumstances and/or may be limited in scope, including but not limited to speech therapy, occupational therapy, temporomandibular joint (TMJ) syndrome, infertility, procedures that may have a cosmetic effect, and physical therapy. Predetermination of benefits is recommended to help you determine your Out-of-Pocket Expense. Also, some benefits require Prior Authorization or precertification (for behavioral health services); therefore, it is important that you call UHC for information on covered services. If you have any questions about how to obtain a predetermination of benefits, contact UHC customer service at 877-835-9855.

Non-Emergency or Non-Urgent Care Away from Home

UHC and UBH have contracted with providers in more than 370 metropolitan areas. If you are not experiencing an Emergency or urgent situation, call the NurseLine at 800-563-0416 for assistance. They will provide you with immediate access to an experienced registered nurse, 24 hours a day, seven days a week, to obtain information on health concerns, questions, as well as information on in-network providers in the area. You can also find a Designated Virtual Network Provider by going to www.myuhc.com or by calling the telephone number on your ID card.

If there are no in-network providers within a 30-mile radius of your location, contact UHC Customer Service at 877-835-9855 for assistance.

Provider Networks

Network availability depends on the ability of the administrator to contract with provider networks. UHC and UBH have contracted with networks across the country. The network of behavioral healthcare Specialists is managed by United Behavioral Health (UBH), the company within UHC that handles mental health and Substance Abuse. You may access in-network PPO providers in most areas nationwide.

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

UHC/UBH's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

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

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

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

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

UnitedHealth Premium® Designation Program

The UnitedHealth Premium® Designation Program is a program developed by UHC, for informational purposes only, to be used as a guide to choose a physician. Please note that this Program is available in 41 states (148 markets) across the United States.

The Premium Designation Program for physicians uses criteria and measures from nationally recognized organizations, such as the National Quality Forum, Ambulatory Care Quality Alliance and the National Committee for Quality Assurance, that identify evidence-based and/or consensus-based standards for treating medical conditions across 25 specialty areas.

To be evaluated, a physician must have at least five patients or surgical procedures treating UHC members within the period evaluated for the conditions and surgical procedures we evaluate in the program. Physicians who do not have at least five patients or procedures treating UHC members are displayed as having "insufficient data with UHC."

Designation is a two-stage process. The first stage is an evaluation of quality based on analysis of 12-36 months of collected claims and/or practice data for UHC members compared to specialty specific national quality standards. Physicians whose claims data demonstrates that they meet or exceed quality criteria, as measured against national quality standards, are designated as having met quality criteria.

Physicians are also evaluated for the cost efficiency of the care that they provide. Cost efficiency is based on factors such as the use and price of diagnostic testing, prescribed medications, procedures and follow-up care in comparison to other physicians in the same specialty in the same geographic area. To make an "apples to apples" comparison in the cost efficiency for doctors, we make an adjustment to account for the types of patients, severity of illness and patients' conditions that the particular doctor treats.

Patients are grouped based on similar characteristics using complete "episodes of care," which includes physician care, inpatient and Outpatient hospital services, laboratory testing, X-rays, drug and other available claims associated with each patient for treatment of a condition.

A cost efficiency score is calculated by comparing a doctor's actual episode costs to the local market average for similar episodes treated by similar Specialists. Doctors who are more efficient in comparison to the local market average will receive the UnitedHealth Premium cost efficiency designation. Refer to www.myuhc.com for more information on this Program.

IMPORTANT: The information from the Premium designation program is not an endorsement of a particular physician or healthcare professional's suitability for your healthcare needs. UHC does not provide healthcare services nor practice medicine. Physicians are solely responsible for medical judgments and treatments. The designation of a physician does not guarantee the quality of healthcare services you will receive from a doctor and does not guarantee the outcome of any healthcare services you will receive. Likewise, the fact that a physician may not be designated by this program does not mean that the physician does not provide quality healthcare services. All physicians in the UnitedHealth Network have met certain minimum credentialing requirements. Regardless of whether a physician has received a designation, you have access to all physicians in the UnitedHealth Network, as described in this Benefit Program Summary.

Provider Directories

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

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

Provider Searches Online

To search for a provider online, go to www.myuhc.com. It is easy and only takes a few minutes. All that is needed is access to the Internet. If you are not enrolled with UHC, enter "SNL" as user name and password.

- Log on to www.myuhc.com (you will need to register)
- To find medical providers, select Physicians & Facilities
- To find a physician, select Find a Physician
- To find a hospital, select Find a Hospital
- To find behavioral health providers, select Find Mental Health/Substance Abuse Care. Click on "Go to Live and Work Well"

Employee Assistance Program (EAP)

Sandia offers employees enrolled in the Sandia Total Health Program and their covered dependents an Employee Assistance Program (EAP) for counseling services. The EAP counseling services are designed to provide assessment, referral, and follow-up to employees experiencing impairment from personal concerns such as health, marital, family, financial,

substance abuse, legal, emotional, stress, or other personal concerns that may adversely affect day-to-day activity.

Your EAP benefit allows up to eight visits a year to in-network EAP providers at no cost to you. Obtain a referral to an EAP counselor by contacting LifeEra (a division of UHC) at 866-828-6049, 24 hours a day, seven days a week.

You also have access to an interactive website that provides electronic access and delivery of your EAP benefit, as well as resources and tools to help you enhance your work, health, and life. You can access this website by either registering on www.myuhc.com, selecting Physicians & Facilities, or by going to www.liveandworkwell.com (without registering) and enter SNL as the access code. This website allows you to:

- Check your EAP benefits information and request services online
- Look up health facts and read articles on Life Event issues
- Use a host of financial calculators and other interactive tools
- Join interactive discussions, chats, and message boards on a variety of health and wellness topics
- Take quizzes and participate in customized self-improvement programs

Precertification Requirements for EAP Services

Contact LifeEra at 866-828-6049 to receive Precertification for EAP services. If Precertification is not obtained, no reimbursement will be allowed.

Note: Retirees, survivors, and LTD terminees and their covered dependents are not eligible for EAP benefits.

Virtual Visits

Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or healthcare specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

You can utilize the virtual visits benefit for commonly treated conditions when your primary care doctor is not available, you are traveling, or before visiting the emergency room or urgent care facility for a non-emergency health condition. Commonly treated conditions include:

- Allergies/asthma
- Bladder infection/urinary tract infection
- Bronchitis
- Cold/flu

- Diarrhea
- Ear infection
- Fever
- Joint aches
- Migraine/headaches
- Pink eye
- Rash
- Sinus problems
- Sore throat
- Stomach ache

You can find a Virtual Network Provider by going to www.myuhc.com or by calling the telephone number on your ID card. There is a \$25 copay for virtual visit services that do not apply to the Deductible, but apply to the out-of-pocket maximum (tele-behavioral health visits follow the behavioral health benefit).

Note: Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.

Benefits under this section do not include email, or fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (CMS defined originating facilities).

Advocate4Me NurseLine

Questions about health can come up at any time, which is why it is important to have easy access to a trusted source of information and support 24 hours every day. With the Advocate4Me NurseLine, you have such a source – available through telephone conversations, the Internet, or informational recorded messages.

Telephone

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

- A recent diagnosis
- A minor Sickness or Injury
- Men’s, women’s, and children’s wellness
- How to take prescription drugs safely
- What questions to ask your doctor before a visit
- For help understanding your test results
- Information that can help you decide when the Emergency room, Urgent Care, a doctor visit, or self-care is appropriate
- Self-care tips and treatment options

- Healthy living habits
- Any other health related topic

Informational Recorded Messages

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

Live Nurse Chat

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

IMPORTANT: If you have a Medical Emergency, call 911, not the NurseLine.

UnitedHealth Personal Health Support Program

UnitedHealthcare offers those who are living with a chronic condition or dealing with complex healthcare needs the UnitedHealth Personal Health SupportSM Programs. The goal of these Programs is to provide a high level of support and help you become as informed as possible. These Programs can be accessed at no additional cost to you. If you have questions about or feel you may benefit from these Programs, call 877-835-9855.

Case Management Program

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

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

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

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

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

Additional benefits of having a primary nurse include:

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

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

Disease Management Program

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

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

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

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

Centers of Excellence (formerly United Resource Networks (URN) Programs)

UHC offers designated Centers of Excellence (COE) programs for congestive heart disease, cancer services, and organ transplants for you. Individuals with complex, unusual, or rare medical conditions have a likelihood of better outcomes when they are diagnosed and treated

by medical professionals with precise clinical expertise. The COE programs were developed to support safe, successful, and cost-effective support of individuals with these conditions. These programs are optional and are not required in order to receive benefits; however, your costs may be lower due to typically better COE Program negotiated rates with UHC. In addition, you may have access to additional facilities on an in-network basis through these programs. Finally, for transplants, cancer and congenital heart disease services, you may be eligible for a travel and lodging benefit through these programs as described on the following page. To COE will assist the patient and family with travel and lodging arrangements related to:

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

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

The Sandia Total Health Program covers expenses for travel and lodging for the patient and a companion as follows:

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

UHC must receive valid receipts for such charges before you will be reimbursed.

Reimbursement for certain lodging expenses for the patient and their companion(s) may be included in the taxable income of the subscriber if the reimbursement exceeds the per diem rate.

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

- Airfare at economy or coach rate
- Taxi or ground transportation (not including limos or car services)

- Parking
- Boat
- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and designated provider, and/or
- Tolls

A combined overall maximum benefit of \$10,000 per covered patient applies for all travel and lodging expenses reimbursed under this Program in connection with all cancer treatments and transplant procedures and CHD treatments during the entire period that person is covered under this Program.

Transplant Resource Services Program (Organ and Tissue Transplantation)

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

- The Transplant Resource Services Premium Network provides access to clinical and financial excellence in transplantation. Patients benefit from network usage with the opportunity for improved outcomes and significant cost savings associated with transplantation, along with the wealth of clinical information available on each network physician and/or healthcare professional to assist in the patient referral process.
- Benefits are available to the donor and the recipient when the recipient is covered under the Sandia Total Health. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which the Program will pay for include but are not limited to:
 - Blood/Marrow
 - Heart
 - Heart/Lung
 - Intestinal
 - Intestinal/Liver
 - Kidney
 - Kidney/Pancreas
 - Liver
 - Liver/Kidney
 - Lung
 - Pancreas
 - Pancreas after kidney

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

- Pre-transplant evaluation
- Hospital and physician fees
- Organ acquisition and procurement, blood/marrow acquisition and donor search charges
- Transplant procedure

- Up to one year of follow-up care for transplant-related services
 - The Transplant Access Program – for geographic access, economic value and administrative relief. The Transplant Access Program provides discounted rates for transplantation at a number of medical centers throughout the United States that are not in the Transplant Resources Premium Network. Participating Transplant Access Program physicians and other healthcare professionals do not undergo Transplant Resource Services’ rigorous credentialing process; therefore, clinical information regarding these providers is not available to promote referral.
 - Extra Contractual Services – for contracting expertise on a case-by-case basis. These services are available on a case-by-case basis for patient referrals that fall outside of The Transplant Resource Services Premium Network or The Transplant Access Program.

For information on coverage, refer to [Section 6: Covered Medical Plan Services & Limitations](#).

Cancer Resource Services Program

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

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

For information on coverage, refer to [Section 6: Covered Medical Plan Services & Limitations](#).

Congenital Heart Disease Resource Services Program

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

Goals of CHD Resource Services include:

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

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

Shared Savings Program

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

When you seek healthcare outside the UnitedHealthcare network, your resulting out-of-pocket costs will generally be higher. However, when you receive healthcare from physicians and facilities which are part of the Shared Savings program, UnitedHealthcare may obtain a discount to an out-of-network provider’s billed charges. This discount is usually based on a schedule previously agreed to by the out-of-network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and deductibles would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case the provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Depending on the geographic area and the service you receive, you may have access to out-of-network providers who participate in the Shared Savings Program and have agreed to discount their charges for Covered Health Services.

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

Healthcare Fraud Information

Healthcare and insurance fraud results in cost increases for healthcare plans. You can help by:

- Being wary of offers to waive copays, coinsurance, and Deductibles. These costs are passed on to you eventually.

- Being wary of mobile health testing labs. Ask what your healthcare insurance will be charged for the tests.
- Reviewing the bills from your providers and the Explanation of Benefits (EOB) form you receive from UHC. Verify that services for all charges were received. If there are any discrepancies, call UHC Customer Service.
- Being very cautious about giving information about your healthcare insurance over the phone.

If you suspect fraud, contact the UHC Fraud Department at 877-835-9855.

Section 4. Deductibles, Out-of-Pocket Limits and Lifetime Limits

This section summarizes the annual Deductibles and Out-of-Pocket Limits (formerly known as Maximum) that apply to the in-network option and the out-of-network option, as well as any lifetime limits under the Sandia Total Health Program.

Note: If you do not have access to UHC Network providers within a 30-mile radius of your home, you will be covered under the in-network level of benefits under the Out-of-Area Plan. When you access providers, UHC determines who will be placed in the Out-of-Area Plan. Reimbursement is based on billed charges.

Deductibles

This section describes your Deductibles. You must first pay the annual Deductible before the Program begins to pay for Covered Health Services. When you meet the full Deductible amount, the Program begins to pay for eligible, covered expenses at the applicable Coinsurance amount. Deductibles are not prorated for mid-year enrollments.

If you retire mid-year and are PreMedicare, any amounts applied toward your Deductibles under your employee coverage will transfer to your retiree coverage.

If you change medical plans mid-year (e.g. you move from the Kaiser STH Program to this Program), any amounts applied toward your Deductible under Kaiser will be applied to this Program; however, you must contact Kaiser to have your Deductible amount transferred.

Amounts above Eligible Expenses, charges not covered by the Program, prescription drug Coinsurance, virtual visit copay, and charges incurred because of failure to obtain required Prior Authorization or precertification do not apply toward the Deductible.

Annual Deductible					
In-Network Option			Out-of-Network Option		
Primary Covered Member Only	Primary Covered Member + Spouse or + Child(ren)	Primary Covered Member + Spouse + Child(ren) (also referred to as family)	Primary Covered Member Only	Primary Covered Member + Spouse or + Child(ren)	Primary Covered Member + Spouse + Child(ren) (also referred to as family)
\$750	\$1,500	\$2,250	\$2,000	\$4,000	\$6,000
<p>Note: The Deductibles between in-network and out-of-network do not cross apply. UHC will notify you via the monthly health statement when the Deductible has been reached. You can always view your personal plan information online via www.myuhc.com.</p>					

Each family member may contribute toward the family Deductible based on usage; however, contribution maximums are limited to the individual Deductible amount.

After three members in a family meet the individual Deductible, the family Deductible is satisfied. No more than the individual Deductible amount will be applied to the family limits per member.

Example: An employee has a family of five members. The in-network Deductible for this family is \$2,250. During the calendar year, the father and mother each incurred in-network expenses of \$1,000 and \$500, respectively. The three children incurred in-network expenses as follows: first child, \$500; second child, \$1,000; third child, \$200. These expenses are determined to be covered charges and are applied to the Deductible by the Claims Administrator in the order of receipt of the claims. The individuals contribute to the Deductible as follows:

In-Network Deductible Example			
Covered Member	Expenses Incurred	Individual Limit	Allowable Contribution
Father	\$1,000	\$750	\$750
Mother	\$500	\$750	\$500
1st Child	\$500	\$750	\$500
2nd Child	\$1,000	\$750	\$500
3rd Child	\$200	\$750	\$0
Total:			\$2,250

After these charges are applied to the family Deductible, no additional charges are applied even though some family members have not met the individual Deductible.

Example: A retiree has himself and his spouse covered. The in-network Deductible for him and his spouse is \$1,500. During the calendar year, each incurred in-network expenses of \$1,000 and \$1,500, respectively. These expenses are determined to be covered charges and are applied to the Deductible by the Claims Administrator in the order of receipt of the claims. The individuals contribute to the Deductible as follows:

In-Network Deductible Example			
	Expenses Incurred	Individual Limit	Allowable Contribution
Retiree	\$1,000	\$750	\$750
Spouse	\$1,500	\$750	\$750
Total:			\$1,500

After these charges are applied to the Deductible, no additional charges are applied.

Deductibles for Admissions Spanning Two Calendar Years

If a Deductible has been met while you are an inpatient and the admission continues into a new year, no additional Deductible is applied to that admission's Covered Health Services. However, all other services received during the new year are subject to the applicable Deductible for the new year.

Coinsurance

In addition to your Deductible, if applicable, you pay Coinsurance of 20% of the Covered Charge for UHC in-network services, and 40% of the Covered Charge for out-of-network services. Please be aware: The difference between the Covered Charge and a provider's billed charge can be significant; an out-of-network provider can bill you for this difference.

Certain preventive care as outlined under Coverage Details is provided at 100% coverage when you receive the services from an in-network provider, or if you receive services out-of-network, coverage is at 60% of the Medicare-Approved Amount, after the Deductible (out-of-network balance billing may apply). For information on non-covered services, refer to [Section 8: What's Not Covered – Exclusions](#).

IMPORTANT: You are responsible for any amount above the Medicare-Approved Amount if you receive services out-of-network.

Some services require Prior Authorization (see [Section 3: Accessing Care](#) for a complete listing of these services). If Prior Authorization is not obtained, you will receive reduced benefits or, in certain cases, no benefits.

Out-of-Pocket Limits

This section describes your Out-of-Pocket Limits. **Note:** Out-of-Pocket Limits are not prorated for mid-year enrollments.

If you retire mid-year and are PreMedicare, any amounts applied toward your out-of-pocket limits under your employee coverage will transfer to your retiree coverage.

If you change medical plans mid-year (e.g. you move from the Kaiser Permanente Program to the UnitedHealthcare Program), any amounts applied towards your out-of-pocket limit under Kaiser Permanente will be applied under this Program; however, you will need to contact Kaiser Permanente to have the amount transferred).

If you are dual Sandians and you switch coverage mid-year due to a mid-year qualifying event, any amounts applied towards out-of-pocket limits will transfer (e.g. you marry another Sandian and you change your coverage to be enrolled under your spouse, any amounts applied towards your out-of-pocket limits, as a Primary Covered Member, will be applied towards your dependent Deductible under this program). However, you will need to contact your former administrator to have the amount transferred.

Medical Expenses Incurred through UnitedHealthcare

Annual Out-of-Pocket Limit					
In-Network Option			Out-of-Network Option		
Primary Covered Member Only	Primary Covered Member + Spouse or + Child(ren)	Primary Covered Member + Spouse + Child(ren) (also referred to as family)	Primary Covered Member Only	Primary Covered Member + Spouse or + Child(ren)	Primary Covered Member + Spouse + Child(ren) (also referred to as family)
\$2,750	\$5,500	\$8,250	\$6,500	\$13,000	\$19,500
<p>Note: The annual Out-of-Pocket Limit includes the Deductible. The Out-of-Pocket Limits do not cross apply between in-network and out-of-network. UHC will notify you via the monthly Health Statement when the Out-of-Pocket Limit has been reached. You can always view your personal plan information online via www.myuhc.com.</p>					

With some exceptions, no additional Coinsurance will be required for the remainder of the calendar year after you reach the applicable annual out-of-pocket Eligible Expenses:

- For you: when you use the in-network option and meet your in-network Out-of-Pocket Limit for covered medical expenses.
- For you (and your spouse) or you (and your child[ren]): when you (and your spouse or child[ren]) use the in-network option and meet the in-network Out-of-Pocket Limit for covered medical expenses.
- For the family: when your family uses the in-network option and meets the in-network Out-of-Pocket Limit for covered medical expenses.
- For you: when you use the out-of-network option and meet your out-of-network Out-of-Pocket Limit for covered medical expenses.
- For you (and your spouse); or you (and your child[ren]): when you (and your spouse or child[ren]) use the out-of-network option and meet the out-of-network Out-of-Pocket Limit for covered medical expenses.
- For the family: when your family uses the out-of-network option and meets the out-of-network Out-of-Pocket Limit for covered medical expenses.

Example: In a calendar year, an employee family of four meets the in-network family \$8,250.

Out-of-Pocket Limits are as follows:

In-Network Out-of-Pocket Limit Example			
	Out-of-Pocket Expenses In-Network	Applied to Out-of-Pocket In-Network	Applied to Out-of-Pocket Out-of-Network
Employee	\$2,750	\$2,750	\$0
Spouse	\$2,750	\$2,750	\$0
1st Child	\$2,750	\$2,750	\$0
2nd Child	\$0	\$0	\$0
Total:	\$8,250	\$8,250	\$0

The total in-network Out-of-Pocket Limit for the family has been met. For the remainder of the calendar year, any additional covered medical expenses submitted by this family under the in-network option will be paid at 100% of Eligible Expenses (except for prescription drugs obtained through Express Scripts). If any member of this family, however, seeks out-of-network care, the in-network Out-of-Pocket Limits will not apply.

Example: In a calendar year, a retiree and his spouse meet the in-network \$5,500 Out-of-Pocket Limit as follows:

In-Network Out-of-Pocket Limit Example			
	Out-of-Pocket Expenses In-Network	Applied to Out-of-Pocket In-Network	Applied to Out-of-Pocket Out-of-Network
Retiree	\$3,500	\$2,750	\$0
Spouse	\$10,000	\$2,750	\$0
Total:	\$13,500	\$5,500	\$0

The total in-Network Out-of-Pocket Limit for the retiree plus spouse has been met. For the remainder of the calendar year, any additional covered medical expenses submitted by under the in-network option will be paid at 100% of Eligible Expenses (except for prescription drugs obtained through Express Scripts). If the retiree or spouse, however, seeks out-of-network care, the in-network Out-of-Pocket Limits will not apply.

The following table identifies what does and does not apply toward in-network and out-of-network Out-of-Pocket Limits:

Features	Applies to the In-Network, Out-of-Pocket Limit?	Applies to the Out-of-Network, Out-of-Pocket Limit?
Payments toward the annual Deductible	Yes	Yes
Member Coinsurance payments	Yes	Yes
Charges for non-covered Health Services	No	No
Amounts of any reductions in benefits you incur by not following Prior Authorization or precertification requirements	No	No

Features	Applies to the In-Network, Out-of-Pocket Limit?	Applies to the Out-of-Network, Out-of-Pocket Limit?
Amounts you pay toward behavioral health services	Yes	Yes
Charges that exceed Eligible Expenses	Not applicable	No
Prescription drugs obtained through Express Scripts	No	No

Prescription Drug Expenses Incurred through Express Scripts

Once a covered member has met his or her \$1,500 Out-of-Pocket Limit for the year, no additional Coinsurance will be required for that member for covered in-network prescription drugs for the remainder of the calendar year.

	In-Network Option	Out-of-Network Option
Annual Out-of-Pocket Limit	\$1,500 per person \$5,950 for a Family	None

IMPORTANT: The in-network Out-of-Pocket Limit does not apply to prescription drugs purchased out-of-network, therefore, if you have met your in-network per person annual Out-of-Pocket Limit, and you purchase a prescription at an out-of-network retail pharmacy, you will be responsible for the applicable Coinsurance amount. Refer to [Section 7: Prescription Drug Program](#), for information on your prescription drug benefits.

Lifetime Limits

The Sandia Total Health Program does not have any lifetime limits, with the exception of the infertility benefit as described in the [NTESS Health Benefits Plan for Employees Summary Plan Description](#).

When you reach the \$30,000 lifetime limit benefit, no additional reimbursement for any procedures incurred to treat infertility are payable. Other covered procedures related to family planning or reproduction (excluding infertility) may be payable. Refer to [Section 6: Covered Medical Plan Services & Limitations](#).

Travel and lodging: a combined overall maximum benefit of \$10,000 per covered recipient applies for all travel and lodging expenses reimbursed. This applies to all treatments during the entire period that the recipient is covered under this medical plan.

Section 5. Health Reimbursement Account

To be eligible for HRA funding, you must be enrolled in the Sandia Total Health Medical Plan.

Health Reimbursement Account (HRA) Amounts

The HRA is an arrangement that will allow you to determine how some of your healthcare dollars are spent. Sandia will allocate an amount to the account that is based on:

- Your coverage and enrollment status (active, PreMedicare/single, family, etc.),
- Whether or not you and your covered spouse have completed a Health Assessment through the Virgin Pulse Program website, and
- Whether or not you and your covered spouse have participated in the Virgin Pulse Incentive Program.

Annual Allocation of HRA Contributions

Coverage Category / Tier	Virgin Pulse Activity Completion	Health Assessment is Taken	Health Assessment is NOT Taken	Total Possible HRA allocation ¹
Employee only	Maximum \$250 ²	\$250	\$0	\$500
Employee + spouse ¹	Maximum \$500 ² (\$250 max each employee and spouse)	Maximum \$500 (\$250 each employee and spouse)	\$0	\$1,000
Employee + child(ren) ¹	Maximum \$250 ²	\$500 (employee completes)	\$250	\$750
Employee + spouse +child(ren) ¹ (family)	Maximum \$500 ² (\$250 max each employee and spouse)	Maximum \$750 (both employee and spouse complete)	\$250	\$1,250

¹ This is the only amount that will be placed in your HRA during the calendar year and may be used for any combination of eligible in-network and out-of-network Covered Health Services, including eligible 213(d) expenses.

² Includes health action plan completion of employee and/or spouse for \$50 HRA contribution. PreMedicare retirees and their spouses, surviving spouses and dependents, and long term disability terminatees are not eligible to participate in Virgin Pulse for HRA credit.

The HRA is entirely funded by Sandia and not taxable to you. You are not permitted to make any contribution to your HRA, whether on a pre-tax or after-tax basis. Your HRA is an “unfunded” account, and benefit dollars are payable solely from Sandia’s general assets.

Both the primary covered member and covered spouse are responsible for completing the health assessment to receive the full HRA contribution. Other covered dependents are not required to complete a health assessment.

Note: In order to receive HRA funding for each calendar year, **employees and their spouses** must complete their Health Assessments by **December 31** of the previous year. If the Health Assessment is completed by **November 30** of the previous year, HRA funds will be received by January 1.

PreMedicare retirees and their PreMedicare spouses, PreMedicare surviving spouses, and PreMedicare long term disability terminees and their spouses are required to complete their Health Assessment through the UHC website from October 1 through **September 30** in order to receive funding in the following year.

PreMedicare retirees (and their spouses) who were active employees for a portion of the current year and completed their Health Assessment(s) prior to retirement must complete a new Health Assessment in the current year through BCBSNM by September 30 in order to receive funding for the following year.

If you don't spend all your HRA dollars in a calendar year, and you remain enrolled in the Sandia Total Health Program for the following year, any remaining HRA balance remains in the HRA for the next calendar year. The maximum balance in an HRA is capped at:

- \$1,500 for Primary Covered Member only coverage
- \$3,000 for Primary Covered Member plus spouse or plus child(ren)
- \$4,500 for family coverage

Events Resulting in Loss of HRA Funds

The maximum balance in an HRA at the beginning of any new year is capped at the amounts shown above. If you have an event which forces you to change coverage, your HRA balance will be adjusted accordingly at the beginning of the next calendar year. Example: You are enrolled as Primary Covered Member + spouse and get divorced. At the time of the divorce you have \$2,500 in your HRA. You may keep the HRA funds through the end of the calendar year, but the HRA balance will be reduced to \$1,500 beginning January 1 of the following calendar year, as that is the maximum balance for Primary Covered Member Only coverage. For example, if you incur an out-of-pocket medical expense of \$2,000 in December that you file in January, you will only have \$1,500 in your HRA to cover that medical expense. **Note:** Expenses incurred in the previous plan year cannot be paid with HRA funds that were earned for the current plan year.

If you terminate employment or lose coverage, you have 90 days to file claims for expenses incurred while you were covered under Sandia Total Health Plan. If you do not use your HRA funds and do not elect COBRA coverage, you forfeit any remaining HRA funds. Refer to [NTESS Health Benefits Plan for Employees Summary Plan Description](#) for information on continuing coverage under COBRA.

If you are a PreMedicare Retiree with no enrolled dependents, and you become Medicare-eligible, you have 90 days from date of Medicare eligibility to file claims for expenses incurred while you were under the Sandia Total Health plan. Any HRA funds remaining after 90 days will be forfeited.

Note: If you are new to this plan at the start of the plan year and were previously enrolled in a different Sandia Total Health Medical plan, any HRA funds will not rollover until 90 days after the end of the previous calendar year. If you have any remaining funds in the HRA from the previous year, the balance will not rollover to the next year until 90 days after the end of the plan year. This ensures that your current carrier has access to your prior year HRA funds to pay for claims for medical services received in the previous year but processed during this 90-day window.

New Hires

Sandia will automatically make the full applicable Health Assessment portion of the HRA contribution (see [Annual Allocation of HRA Contributions](#) table) for the calendar year in which you hire. To receive the Health Assessment portion of the HRA contribution for the next calendar year, you and your covered spouse must complete the Health Assessment by December 31 to receive funds by February 1 of the new calendar year, or by November 30 to receive funds by January 1 of the new calendar year.

Eligible Mid-Year Election Change Events

Sandia will automatically make the applicable HRA contribution for any employees, PreMedicare retirees, and/or their dependents who enroll in Sandia Total Health during the calendar year as a result of an eligible mid-year election change event. Examples include:

- If you have waived coverage because you have coverage elsewhere, and you lose that coverage and enroll in the Sandia Total Health Program within 31 calendar days of the loss of coverage, Sandia will contribute the applicable HRA contribution.
- If you get married mid-year, Sandia will contribute the applicable additional HRA contribution (\$250 to include spouse coverage or \$500 for family coverage) if you enroll your new eligible family members within 31 calendar days of marriage.

Open Enrollment Changes for Dual Sandians

If you switch Primary Covered Members during Open Enrollment, the total combined HRA will be assigned to the new Primary Covered Member on or around April 1.

If you have Primary Covered Member + Spouse or Primary Covered Member + Family coverage and switch to Primary Covered Member only coverage, the HRA funds will remain with the original Primary Covered Member.

If you switch from Primary Covered Member or Primary Covered Member + child(ren) coverage to Primary Covered Member + Spouse or Primary Covered Member + Family coverage, the HRA funds will remain with the original Primary Covered Member.

What Healthcare Expenses are Eligible for HRA Reimbursement

Your Health Reimbursement Account may only be used for all qualified 213(d) expenses, which include eligible medical, dental, vision, and prescription expenses. For example, if you receive elective cosmetic surgery that is not eligible under Sandia Total Health, these claims are not eligible for payment by the HRA.

Note: Expenses incurred in the previous plan year cannot be paid with HRA funds that were earned for the current plan year.

How the HRA Works

Your HRA dollars can be used to pay for Eligible Expenses, including eligible dental, vision or prescription drugs purchased through Express Scripts, up to the amount allocated to your HRA. HRA funds are available for use by any Covered Member and are not apportioned on a per person basis. For example, if there is \$750 in available HRA funds and a claim is submitted for one member in the amount of \$1,000, and the member has a \$750 Deductible, the full HRA funds of \$750 will be pulled to cover the Deductible portion of the claim.

Example 1

Year 1:

You complete a Health Assessment and you have Primary Covered Member only coverage at the beginning of the year. Sandia allocates \$250 to your HRA. During the course of the year, you incur \$150 in eligible medical services. Your annual in-network Deductible is \$750, and the entire \$150 of medical services you received is subject to the Deductible. You may use your HRA to cover the Deductible amount.

HRA Beginning Balance	\$250
<u>Less HRA payment</u>	<u>(-\$150)</u>
HRA Ending Balance	\$100

- Your HRA balance is sufficient to cover the entire \$150 of your annual healthcare costs. This means that the entire amount that was subject to the Deductible has been paid by the HRA. You effectively have no out-of-pocket costs.
- You have \$100 of unused funds in your HRA that will rollover to the next calendar year if you continue enrollment in the Sandia Total Health Program.

Year 2:

You complete a Health Assessment for this year, and you have Primary Covered Member only coverage at the beginning of the year. Sandia allocates \$250 to your HRA. You start the year with a balance of \$350 (\$100 from the previous year plus \$250 from this year). During the course of the year, you incur \$100 in eligible medical services. Your annual in-network

Deductible is \$750, and the entire \$100 of health services you received is subject to the Deductible. You may use your HRA to cover the Deductible amount.

HRA Carryover Balance	\$100
Plus Year 2 HRA	<u>\$250</u>
Year 2 Beginning Balance	\$350
<u>Less HRA payment</u>	<u>(-\$100)</u>
Year 2 Ending Balance	\$250

- Your HRA is sufficient to cover the entire \$100 of your annual healthcare costs. This means that the entire amount that was subject to the Deductible has been paid. You effectively have no out-of-pocket costs after your HRA has paid your member portion.
- You have \$250 of unused funds in your HRA that will rollover to the next calendar year if you continue enrollment in the Sandia Total Health Program.

Year 3:

You complete a Health Assessment for this year and you have Primary Covered Member only coverage at the beginning of the year. Sandia allocates \$250 to your HRA. During the course of the year, you incur \$1,500 in eligible health services. Your annual in-network Deductible is \$750. The first \$500 of medical expenses is paid by your HRA and also counts toward your annual in-network Deductible of \$750.

HRA Carryover Balance	\$250
Plus Year 3 HRA	<u>\$250</u>
Year 3 Beginning Balance	\$500
<u>Less HRA payment</u>	<u>(-\$500)</u>
Year 3 Ending Balance	\$0

- Your HRA will cover \$500 of your \$750 Deductible. This means that you need to pay an additional \$250 to meet your annual Deductible. You will then be subject to 20% on the remaining \$750 of medical expenses which is \$150. Your total out-of-pocket cost is \$400.

Note: For simplicity, dental, vision or pharmacy expenses were not illustrated in the examples. But these expenses can also be paid for with the HRA automatically for inpatient medications or using the UHC Healthcare Spending Debit Card for use at a dentist/physician office or retail or mail-order pharmacy.

Example 2

You have enrolled yourself and your spouse but have not completed a Health Assessment for the year but your Spouse does. You do not receive your \$250 but Sandia allocates \$250 to your HRA for your spouse, therefore, you start the year with a balance of \$250. During the course of the year, you and your spouse incur \$600 in Eligible Expenses. Your annual in-network Deductible is \$750 per person or \$1,500 for you and your spouse. The entire \$600 of health services you and your spouse received is subject to the Deductible.

HRA Beginning Balance	\$250
<u>Less HRA payment</u>	<u>(-\$250)</u>
HRA Ending Balance	\$0

- The HRA can be used to reimburse the \$250 of your and your spouse’s annual healthcare costs. You had \$600 in costs; the first \$250 of the Deductible is paid by the HRA. This means that you must pay an additional \$350 to meet your annual Deductible
- There is no remaining balance to roll over to the next calendar year, but at the beginning of the next calendar year Sandia will again allocate another amount to your HRA, (\$0 again if you both don’t take the Health Assessment, \$500 if you both do) if you have employee plus spouse coverage at the beginning of the year. These funds can be used to pay for some or all of that calendar year’s health costs.

UHC Healthcare Spending MasterCard

UHC will issue you a debit card called the UHC Healthcare Spending MasterCard (debit card). Two cards are sent for convenience. Additional cards may be requested by calling 866-755-2648. Additional cards are at no cost to you. The debit cards are issued with the Primary Covered Member’s name. However, any covered member can use them.

There is no fee for you to use the card, nor does owning this card affect your credit rating.

This debit card can be used for paying eligible 213(d) expenses. See the Claims Processing with an HCFSA and/or HRA section below for important information on how and when to use the card.

Note: If you enrolled in a Healthcare Flexible Spending Account (HCFSA), the same debit card will be used to pay for eligible HCFSA expenses. You will use the debit card to withdraw funds from your HCFSA to help offset healthcare expenses you incur under the Sandia Total Health as well as eligible expenses under the HCFSA. Refer to the [Flexible Spending Accounts Summary Plan Description](#) for more information.

Even though it says debit on the front of the card, it does not require a PIN (personal identification number) for processing, so you should select “credit” at the point of purchase.

If a merchant allows partial authorizations, the card will access only the remaining funds in the account. For example, if the item cost is \$20, and there is only \$10 in the account, you can use the card to fund \$10, and then pay for the remainder of the transaction out-of-pocket. Not all merchants allow partial authorization.

If your debit card doesn't work, or is declined, you should choose another payment method, save the receipt, and submit the claim manually using the [claim reimbursement request form](#).

Reasons why your card may be declined include:

- The card is not activated
- One business day has not passed since activation
- The transaction is not for an eligible service
- The transaction is for a non-eligible charge
- The transaction cannot be substantiated in real time at the pharmacy
- The retailer does not accommodate partial authorization and the remaining funds in the account do not cover the expense
- There is a problem with the merchant's card terminal
- It is an invalid location, e.g. a gas station or electronics store
- The card has been deactivated due to pending unsubstantiated claims

Medical transactions only can be viewed on the HCFSA/HRA statement. You can also go online at www.myuhc.com to view your medical and prescription drug transactions.

Note: When using a debit card to pay for HRA claims, there are certain claims which are not automatically substantiated and require additional documentation (receipts that indicate the date of service, the vendor, the nature of the service and cost). For unsubstantiated claims identified by the HRA administrator, you will receive 3 notifications requesting additional documentation. Following the 3rd notice, debit cards will be inactivated until claim receipt documentation is received. For any unsubstantiated claims remaining after the 3rd notice, the amount of the claims will be added to your W2 income. Please remember to save all FSA and HRA claim receipts.

Claims Processing with an HCFSA and/or HRA

Generally, UHC in-network providers will not collect a payment at the time of service. The provider will bill UHC and UHC will process your claim. Funds will automatically be taken from the HCFSA, if enrolled in the UHC FSA, and then from the HRA to pay the provider. If you do not want this to occur, please visit the [Turning off the Auto-Rollover Feature](#) section for instructions on how to disable this feature.

If you are using an out-of-network provider they may require payment at the time of service. In this case you may want to use your debit card to make the payment. Remember that only the amount available in the HCFSA and HRA may be paid with the debit card.

The HCFSA and HRA will only pay if you have funds available.

You can keep track of the dollars in your HCFSA and HRA by going to www.myuhc.com, calling the toll free number on the back of your ID card, or checking a monthly member statement sent to you by UnitedHealthcare.

IMPORTANT: You cannot be reimbursed from more than one tax-advantaged plan (e.g. HCFSA and HRA) for any single expense. If you receive excess reimbursement, contact UHC Customer Service at 877-835-9855.

Medical Expenses

When you or your covered dependent seeks eligible healthcare services, you must present your UHC identification card.

If you see an in-network provider:

1. The provider will file a medical claim with UHC.
2. If the service requires the Deductible or Coinsurance, UHC will look to see if you have funds in your HCFSA first (if enrolled), then your HRA.
 - a. If you do, UHC will pull the member responsibility share of the cost of the service from your HCFSA and/or HRA.
 - b. HCFSA funds will be paid directly to the provider for in-network medical expenses (otherwise, your HCFSA will reimburse you directly – see [Setting up Direct Deposit](#)).
 - c. HRA funds are paid directly to the provider.
3. Once your UHC claim is processed, all claim and HCFSA and/or HRA activity will be documented and sent to you on your UHC Health Statement. Additionally, if the funds come from your HCFSA you will receive an Explanation of Benefits (EOB) as well.
4. Review the statements for accuracy and contact UHC if you believe there are errors.

If you see an out-of-network provider who does not file a claim:

1. You are responsible for [filing the medical claim with UHC](#).
2. If the service requires the Deductible or Coinsurance, UHC will look to see if you have funds in your HCFSA first (if enrolled), then your HRA.
 - a. If you do, UHC will pull the member responsibility share of the cost of the service from your HCFSA and/or HRA.

- b. HCFSAs and HRAs will be paid directly to you by check (see [Setting up Direct Deposit](#)).
3. Once your UHC claim is processed, all claim and HCFSAs and/or HRAs activity will be documented and sent to you on your UHC Health Statement. Additionally, if the funds come from your HCFSAs you will receive an Explanation of Benefits (EOB) as well.
4. Review the statements for accuracy and contact UHC if you believe there are errors.

Prescription Drugs

When you or your covered dependent needs to purchase a prescription through a pharmacy, you must present your Express Scripts identification card.

If you receive in-network services and you use your debit card to pay your applicable Coinsurance, UHC will pay the pharmacy your portion first out of your HCFSAs (if you have enrolled in one and have funds available), second out of your HRAs (if you have funds available). If no funds are available in either the HCFSAs or HRAs, you will need to pay your Coinsurance through another method.

Once your claim is processed, all HCFSAs and HRAs activity will be documented and sent to you on your UHC Health Statement. You should review this statement for accuracy and contact UHC if you believe there are errors.

Setting up Direct Deposit

If you would like to set-up direct deposit:

1. Go to www.myuhc.com and sign in
2. Go to the Claims & Accounts tab
3. Click **Direct Deposit** under member actions, then complete the Direct Deposit fields

Turning off the Auto-Rollover Feature

If you have an HRA

Your HRA will automatically be used to pay for eligible medical expenses unless you elect to have this feature turned off. To access HRA funds for prescription drug purposes, you can either use your debit card or file the claim manually. If you want to turn off the automatic payment feature:

1. Go to www.myuhc.com and sign in
2. Select the Claims & Accounts tab
3. Click Health Reimbursement Account
4. Click Automatic Payment then Add/Change Automatic Payment Settings
5. Click **Discontinue** for Health Reimbursement Account

If you turn off the automatic HRA feature, you will have to submit claims manually to obtain reimbursement from your HRA. You can download the claim form [here](#).

Note: Whether you turn off the automatic payment feature or not, you can still use your debit card.

If you have both an HCFSA and HRA

If you have unused HCFSA dollars in your previous year HCFSA and plan to use the “grace period” for reimbursement for unused funds to avoid “double dipping,” OR you would like to hold on to your HCFSA funds to pay for other eligible expenses during the year, other than medical, (e.g., dental and vision expenses) - you can log on to www.myuhc.com where you discontinue the automatic payment of your HCFSA/HRA until the rollover funds are used:

1. Go to www.myuhc.com and sign in
2. Select the Claims & Accounts tab
3. Click Health Reimbursement Account
4. Click Automatic Payment then Add/Change Automatic Payment Settings
5. Click **Discontinue** for Flexible Spending Account **and** Health Reimbursement Account

IMPORTANT: If you select to only discontinue the HCFSA, please note that the HRA will also turn off. A member may not override the payment hierarchy of HCFSA pays first then HRA pays second.

If you leave the auto-rollover feature off, you may use your debit card for payment or submit paper claims for payment from your HCFSA/HRA funds.

Health Assessment and Biometric Screenings

A Health Assessment is a confidential online questionnaire that asks you about your health history, lifestyle behaviors (such as smoking and exercise habits) and your willingness to make changes. You will receive a personalized report of your health status and any health risks you may have now or possibly down the road, and how you can take steps to prevent or manage those risks. If you have no health risks, the report will make suggestions for improving or better managing your health and well-being.

When completing a Health Assessment, you will be asked to enter your cholesterol, glucose, height, weight, waist measurement, and blood pressure. You are strongly encouraged to obtain biometric screening to input into the Health Assessment so that you have an accurate picture of your health risks.

Health Assessment Process

Active employees and their spouses must complete a Health Assessment by logging into their Virgin Pulse account. Health Assessments must be completed by November 30 of the current

year to receive funding by January 1 of the following year or by December 31 of the current year for funding for the following year.

PreMedicare retirees, and their PreMedicare spouses, LTD Terminées and their spouses, and Surviving Spouses must complete the Health Assessment by logging in their MyUHC account via the UHC website by September 30 for funding for the following year. If you do not have a MyUHC account, you can register by visiting myuhc.com.

PreMedicare retirees (and their spouses) that retired prior to September 30 of the current year and completed the Health Assessment(s) prior to retirement through Sandia will need to complete a new Health Assessment through UHC by September 30 in order to receive funding.

COBRA participants, their spouses are not required to complete a Health Assessment and \$250 is auto funded to the HRA account for each. Other covered dependents are not required to complete a Health Assessment and \$250 is auto funded to the HRA account regardless of number of dependents.

Biometric Screenings Process

Employees can get a biometric screening at the Sandia Medical Clinic (at no cost) or through their personal physician.

To obtain the screenings through the Sandia Medical Clinic, you can schedule an appointment by calling HR Customer Service at 505-844-4237, option 2 in New Mexico, or option 3 in California.

When you get a biometric screening, a trained technician takes your blood pressure, measurements, and draws blood for analysis. You may be asked if you want fasting or non-fasting lab tests. Fasting lab test results will typically include Total cholesterol, HDL, LDL, Triglycerides, and Glucose. Non-fasting tests report only Total Cholesterol and HDL. Fasting labs yield the most comprehensive lab test results, but either option will provide what is needed for the Health Assessment.

Retirees are not eligible to use the Sandia Medical Clinic and will need to get their biometric screenings done through their personal physician.

Virgin Pulse Incentive Management Program

With Virgin Pulse, employees and their covered spouses may participate in healthy activities and get rewarded - with better health and with points! Participants simply track their activities with a GoZone pedometer or many other tracking devices and apps of your choice listed within the Virgin Pulse Program. Visit <https://app.member.virginpulse.com> for more details.

Health Action Plan

Active employees and their covered spouses are responsible for completing a health action plan to each receive \$50 HRA contribution annually. Health action plans are available only for

active employees through Employee Health Services by visiting healthactionplans.sandia.gov until September 30. Health action plans are available through UHC for both active employees and covered spouses until November 30. Other covered dependents are not required to complete a health action plan.

Retirees, surviving spouses, and Long-Term Disability Terminees, and their dependents, are not eligible for the Virgin Pulse Program. If you participated in the Virgin Pulse Program, as an employee, and retired at the beginning of a calendar year, you will **not** receive any HRA funds in the subsequent calendar year. However, if you participated as an employee and retire on or after January 1 of the subsequent calendar year, any Virgin Pulse that you earned in the previous year will be applied to your employee account on January 1 (so long as you have no break in coverage) and you will be eligible to keep those funds.

Tools and Resources to Become a More Informed Consumer

In addition to the many resources listed in this Program Summary (such as the NurseLine, Virtual Visits, and the Healthy Pregnancy Program), you can also access important tools and resources from UHC and Express Scripts through their websites.

My UHC Website

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

- Learn about health conditions, treatments, and procedures
- Search for in-network providers
- Access all of the content and wellness topics from the NurseLine, including Live Nurse Chat, 24 hours a day, seven days a week
- Access to Virtual Visits for Covered Health Services
- Complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques, and access health improvement resources
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your geographical area
- Use the hospital comparison tool to compare hospitals in your area on various patient safety and quality measures
- Make real-time inquiries into the status and history of your claims
- View eligibility and benefit information
- View and print EOB statements online
- Ask a question regarding a claim

- Print a temporary ID card or request a replacement ID card
- Update dependent coordination of benefits status
- Organize your health information in one place with your online Personal Health Manager and Personal Health Summary

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

Express Scripts Website

The Express Scripts member website, www.express-scripts.com, provides information at your fingertips anywhere and anytime you have access to the Internet. Express-Scripts.com offers practical and personalized tools and information so you can get the most out of your benefits. Log on to:

- Locate retail network pharmacies
- Price prescription drugs at retail network pharmacies and mail service
- Refill prescriptions through mail service
- Find out what drugs are covered under the Program

You can also access the above information on the Express Scripts phone app from any smartphone. Simply enter Express-scripts.com into your smartphone browser or download the app by going to the Apple App Store, Android Market or Blackberry World.

Section 6. Covered Medical Plan Services & Limitations

The Sandia Total Health Program provides a wide range of medical care services for you and your family. This section outlines the benefits available under the Sandia Total Health Program. For information on your prescription drug benefits administered by Express Scripts, refer to [Section 7: Prescription Drug Program](#).

Program Highlights

This Sandia Total Health Program does not have any pre-existing condition limitations. This means, for example, that if you have a condition such as pregnancy or cancer before you begin coverage, you are not required to wait a specific amount of time before you are eligible for medical plan benefit coverage.

If a health service is not listed in this section as a Covered Health Service or listed in the Exclusion Section as a specific exclusion, it may or may not be a Covered Health Service. Contact the UHC Onsite Customer Advocate at the Sandia/New Mexico location in Building 832 at 505-844-0657 or UHC Customer Service at 877-835-9855 for information.

If you do not have access to any UHC network providers within a 30-mile radius of your home, you will be covered under the in-network level of benefits under the Out-of-Area Plan when you access providers. UHC determines who will be placed in the Out-of-Area Plan. Reimbursement is based on billed charges.

The Sandia Total Health Program has a Network Gap Exception provision for Covered Health Services. Under this provision, if there are no in-network providers in the required specialty within a 30-mile radius from your home, contact UHC prior to receiving the service (if possible) to request an exception under this provision to allow in-network benefits for services provided by an out of network provider.

IMPORTANT: Covered Health Services are those health services and supplies that are:

- Provided for the purpose of preventing, diagnosing, or treating Sickness, Injury, mental illness, Substance Abuse, or their symptoms
- Medically Necessary
- Included in this section (subject to limitations and conditions and exclusions as stated in this Program Summary)
- Provided to you, if you meet the eligibility requirements as described in the [NTESS Health Benefits Plan for Employees Summary Plan Description](#) or the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#)
- Medically Necessary

If a health service is not listed in this section as a Covered Health Service, or in [Section 8: What's Not Covered – Exclusions](#) as a specific exclusion, it may or may not be covered. Contact UHC Customer Service at 877-835-9855 for information.

Coverage Details

The following information provides detailed descriptions of the Covered Health Services. Refer to [Section 8: What's Not Covered – Exclusions](#), for information on what is excluded from coverage.

Acupuncture Services

Acupuncture services are covered as follows:

- Services provided by a licensed acupuncturist, doctor of oriental medicine, medical doctor, licensed chiropractor, or doctor of osteopathy, either in- or out-of-network, with no review by UHC required
- A maximum paid benefit of \$750 for acupuncture treatment per calendar year, per Covered Member. This maximum applies to in- and out-of-network acupuncture treatment combined

Allergy Services

Services related to allergies are covered as follows:

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

Ambulance Services

Ambulance services provided by a licensed ambulance service are covered as follows:

Ground Ambulance Services

- For Emergency transportation to the nearest hospital where Emergency health services can be performed is paid at the in-network Benefit Level subject to applicable Deductible and co-insurance.
- Transportation from one facility to another is considered an Emergency when ordered by the treating physician at the in-network Benefit Level subject to applicable Deductible and co-insurance.
- If there is documentation from the ambulance service provider that it does not differentiate between advanced life support and basic life support, the Program will cover the services as billed.

Air Ambulance Services

IMPORTANT: Prior authorization to Personal Health SupportSM is required at least five business days before receiving services or as soon as reasonably possible. If Personal Health SupportSM is not notified, benefits will be reduced by \$300. See [Section 3: Accessing Care](#).

- Air ambulance is covered only when ground transportation is impossible or would put life or health in serious jeopardy.
- Transport by air ambulance to a contracted facility nearest to your established home is a Covered Health Service if your condition precludes his/her ability to travel by a nonmedical transport.
- If you are in line for a transplant and the transplant has been approved by UHC and there are no commercial flights to the city in which the organ is available, the Program will cover the medical transport of the patient via air ambulance or jet (whichever is less expensive).

Auditory Integration Training

Auditory integration training services are covered if the results of the evaluation fall within one of the following guidelines:

- A difference of 20dB or more between the most sensitive and least sensitive frequencies;
- The presence of at least one peak of processes, or an air-bone gap of more than 15 dB;
- Less than 6/11 frequencies perceived at the same intensity level.

Behavioral Health Services

Behavioral health services are subject to reimbursement with demonstrated improvement as determined by UHC.

IMPORTANT: Prior authorization to United Behavioral Health is required for some services. Refer to [Section 3: Accessing Care](#).

The Sandia Total Health Program covers intensive behavioral therapies such as Applied Behavioral Analysis (ABA) for Autism Spectrum Disorders (ASD); any treatments or other specialized services designed for ASD that are backed by credible research and demonstrate that the services or supplies have a measurable and beneficial health outcome and are not considered Experimental or Investigational or Unproven Services.

Mental Health and Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office.

Benefits include the following services:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial hospitalization/day treatment.
- Services at a residential treatment facility.
- Intensive outpatient treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a semi-private room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Prior Authorization Requirement

For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain prior authorization from the MH/SUD Administrator prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization from the MH/SUD Administrator as required, benefits will be subject to a \$300 reduction.

The Sandia Total Health Program covers Outpatient mental health and Substance Abuse services as follows:

- Evaluations and assessments
- Diagnosis
- Treatment planning
- Referral services
- Medication management
- Individual and group therapeutic services
- Intensive Outpatient therapy programs
- Crisis intervention
- Psychological testing, including neuropsychological testing

The Sandia Total Health Program covers inpatient, Partial Hospitalization, and Residential Treatment Facilities for mental health and Substance Abuse services as follows:

- Services received on an inpatient or Partial Hospitalization basis in a hospital or an alternate facility that is licensed to provide mental health or Substance Abuse treatment.
- If you are admitted to a facility and do not meet inpatient criteria, UBH will review to determine whether you meet Partial Hospitalization criteria. If you do meet Partial Hospitalization criteria, only the cost for Partial Hospitalization in that area will be allowed, and you will be responsible for the remainder of the cost.
- Room and board in a semi-private room (a room with two or more beds). **Note:** The Sandia Total Health Program will pay the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice as determined by United Behavioral Health.
- Two Partial Hospitalization days are counted as one 24-hour hospitalization day.
- Services received in a Residential Treatment Facility as long as there are at least six hours of therapy provided every calendar day.

Types of services that are rendered as a medical service, such as laboratory or radiology, are paid under the medical benefits.

If there are multiple diagnoses, the Sandia Total Health Program will only pay for treatment of the diagnoses that are identified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

Cancer Services

Oncology services are covered as follows:

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

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer.

IMPORTANT: Prior authorization to Personal Health SupportSM is required for injectable outpatient chemotherapy and clinical trials. Refer to [Section 3: Accessing Care](#).

UHC provides you with access to designated (COE) provider through the Cancer Resource Services Program. It is not mandatory that you receive services through this Program but if you do, you may be eligible for additional benefits. Refer to [Section 3: Accessing Care](#), for more information.

Clinical Trials

The Sandia Total Health Plan covers routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- cancer;
- cardiovascular disease (cardiac/stroke);
- surgical musculoskeletal disorders of the spine, hip, and knees.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include covered health services:

- for which benefits are typically provided absent a clinical trial;
- required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for Clinical Trials do not include:

- the Experimental or Investigational Service or item. The only exceptions to this are:
 - certain Category B devices;

- certain promising interventions for patients with terminal illnesses; or
- other items and services that meet specified criteria in accordance with UnitedHealthcare’s medical and drug policies.
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be a qualifying clinical trial participant, a clinical trial must meet all the following criteria:

- be sponsored and provided by a cancer center that has been designated by the National Cancer Institute (NCI) as a Clinical Cancer Center or Comprehensive Cancer Center or be sponsored by any of the following:
 - National Institutes of Health (NIH), includes National Cancer Institute (NCI);
 - Centers for Disease Control and Prevention (CDC);
 - Agency for Healthcare Research and Quality (AHRQ);
 - Centers for Medicare and Medicaid Services (CMS);
 - Department of Defense (DOD); or
 - Veterans Administration (VA).
- have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial; and
- the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Sandia Total Health Plan.

Note: Benefits are available when the Covered Health Services are provided by either Network or non-Network providers; however, the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)

You must obtain prior authorization from Personal Health Support as the possibility of participation in a clinical trial exist. If you fail to obtain Prior Authorization as required, benefits will be subject to a \$300 reduction.

Exceptions:

- Clinical trials for which Benefits are available as described under Clinical Trials.

- If you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Experimental or Investigational Service to be a covered health service for that sickness or condition. Prior to such consideration, UnitedHealthcare must determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.

Chiropractic Services

Chiropractic services are covered as follows:

- Services provided by a licensed chiropractor, doctor of oriental medicine, medical doctor, doctor of osteopathy, licensed acupuncturist, or physical therapist, either in- or out-of-network, with no review by UHC required.
- A maximum paid benefit of \$750 for spinal manipulation treatment per calendar year, per Covered Member. This maximum applies to in- and out-of-network benefits combined.

Dental Services

The Sandia Total Health Program covers dental services due to Sickness or Injury when provided by a doctor of dental surgery (DDS) or doctor of medical dentistry (DMD) as follows:

- As a result of accidental Injury to sound, natural teeth and the jaw
- As a result of tooth or bone loss, due to a medical condition (e.g., osteoporosis, radiation to the mouth, etc.)
- Oral surgery, if performed in a hospital because of a complicating medical condition that has been documented by the attending physician
- Anesthesia, hospital and/or ambulatory surgical center expenses for dental procedures when services must be provided in that setting due to disability or for young children as determined by the attending physician
- Dental implants, implant related surgery, and associated crowns or prosthetics are covered in situations where:
 1. Permanent teeth are congenitally missing (anodontia), the result of anodontia is impaired function (e.g., chewing/eating), and the implants are not done solely for cosmetic reasons
 2. Tooth loss occurs as a result of accidental Injury
 3. Tooth loss occurs due to a medical condition such as osteoporosis or radiation of the mouth
- Orthognathic surgery limited to documented skeletal Class II and Class III conditions as determined by cephalometric diagnosis, provided the condition is:

1. Both functional and aesthetic
 2. Not adequately treatable by conventional orthodontic therapy
- Dental services related to medical transplant procedures
 - Initiation of immunosuppressive therapy
 - Direct treatment of cancer or cleft palate

IMPORTANT: If you receive coverage under the Sandia Total Health Program for implants, or crowns or other prostheses required as a result of implants, you cannot submit any remaining portion to the Dental Care Program for coordination of benefits. If you receive coverage under the Dental Care Program for implants, crowns or other prostheses required as a result of implants, you cannot submit any remaining portion to the Sandia Total Health Program.

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

Diabetes Services/Devices/Supplies

The Sandia Total Health Program covers diabetes services as follows:

- Outpatient self-management training and education*
- Medical nutrition therapy services*
- Medical eye examinations (dilated retinal examinations)
- Preventive foot care

*Services must be ordered by a Physician and provided by appropriately licensed or registered health professionals.

The Sandia Total Health Program covers diabetes devices and supplies as follows:

- Continuous glucose monitoring system (see “Important” note below). Criteria includes:
 - Type 1 diabetes or type 2 diabetes requiring basal and bolus insulin AND
 - Willingness to wear the rt-CGM device at least 60% of the time AND
 - Have demonstrated the ability to perform self-monitoring of blood glucose frequently and to adjust the diabetes regimen based on the data obtained with monitoring
- Supplies for external insulin pump and continuous glucose monitoring system.
- Blood glucose meters, if you are diagnosed with diabetes Type I or Type II
- External insulin pumps (see note below). Criteria includes:

- Type 1 diabetes or type 2 diabetes requiring basal and bolus insulin AND
- Inability to achieve adequate glycemic control with intensive insulin therapy* using multiple daily injections (MDI) as evidenced by:
 - A1c >7% and/or
 - Frequent hypoglycemia and/or
 - Marked dawn phenomenon and/or
 - Marked glycemic variability (this may be related to lifestyle issues such as participation in athletics or frequent travel) AND
- Demonstrated ability and motivation to monitor glucose frequently (at least four times daily), count carbohydrates, and adjust the insulin regimen as needed to achieve glycemic control

IMPORTANT: Prior authorization to Personal Health SupportSM is required for insulin pumps and continuous glucose monitoring systems. Refer to [Section 3: Accessing Care](#). For items with a purchase or cumulative rental value of \$1,000 or more, Personal Health SupportSM will decide if the equipment should be purchased or rented, and you must purchase or rent the device from the vendor Personal Health SupportSM identifies.

Diagnostic Tests

Diagnostic tests are covered as follows:

- Laboratory and radiology
- Computerized Tomography (CT) scans
- Position Emission Tomography (PET) scans
- Magnetic Resonance Imaging (MRI)
- Nuclear medicine
- Echocardiograms
- Electroencephalograms
- Sleep studies
- Other diagnostic tests
- Additional requirement for members to obtain prior authorization for MR-guided focused ultrasound

Durable Medical Equipment (DME)

IMPORTANT: Prior authorization to Personal Health SupportSM is required. Refer to [Section 3: Accessing Care](#).

Durable medical equipment is covered as follows:

- Ordered or provided by a physician for Outpatient use
- Used for medical purposes
- Not consumable or disposable
- Not of use to a person in the absence of a Sickness, Injury, or disability
- Durable enough to withstand repeated use
- Appropriate for use in the home
- Preventive care Benefits defined under the U.S. Preventive Care Task Force (USPCTF) requirement include the cost of purchasing one double electric breast pump per Pregnancy in conjunction with childbirth for women who are lactating benefits are only available if breast pumps are obtained from a DME provider, Hospital or Physician.
- Rental of a hospital-grade breast pump following childbirth (not to exceed the total cost of the pump). No coverage for rental of hospital grade breast pump under Preventive Care benefit.

IMPORTANT: For items with a purchase or cumulative rental value of \$1,000 or more, Personal Health SupportSM will decide if the equipment should be purchased or rented, and you must purchase or rent the DME from the vendor Personal Health Support identifies.

Examples of DME include, but are not limited to:

- Wheelchairs
- Hospital Beds
- Equipment for the treatment of chronic or acute respiratory failure or conditions
- Equipment to administer oxygen
- Orthotic appliances when custom manufactured or custom fitted to you
- Oxygen
- Orthopedic shoes:
 - Up to two pairs of custom-made orthopedic shoes per year when necessary due to illness such as diabetes, post-polio, or other such conditions
- Mastectomy bras
 - Up to two bras per calendar year following a mastectomy
- C-PAP machine
- Bilirubin lights
- Braces that stabilize an injured body part and braces to treat curvature of the spine

- Delivery pumps for tube feedings, including tubing and connectors
- Lenses for aphakic patients (those with no lens in the eye) and soft lenses or sclera shells (white supporting tissue of eyeball)
- Cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure

One educational training session will be allowed to learn how to operate the DME, if necessary. Additional sessions will be allowed if there is a change in equipment.

More than one piece of DME will be allowed if deemed Medically Necessary by Personal Health SupportSM (e.g., an oxygen tank in the home and a portable oxygen tank).

At UHC's discretion, benefits are provided for the replacement of a type of durable medical equipment once every three years. If the purchased/owned DME is lost or stolen, the Sandia Total Health Program will not pay for replacement unless the DME is at least three years old. The Sandia Total Health Program will not pay to replace leased/rented DME; however, some rental agreements may cover it if lost or stolen.

Replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed the new purchase price, if the DME breaks or is otherwise irreparable as a result of normal use, or when a change in your medical condition occurs sooner than the three-year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc. for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three-year timeline for replacement.

Note: DME is different from prosthetic devices. Refer to [Prosthetic Devices/Appliances](#) in this section.

Emergency Care

IMPORTANT: If you have a Medical Emergency, go to the nearest hospital Emergency room. These facilities are open 24 hours a day, seven days a week

Medical Emergency care worldwide is covered as follows:

- Emergency services obtained from an in-network provider will be considered at the in-network level of benefits if it is a Medical Emergency.
- Emergency services obtained from an out-of-network provider within the United States will be considered at the in-network level of benefits if it is a Medical Emergency.
- Emergency services obtained from a provider outside the United States will be considered at the in-network level of benefits if it is a Medical Emergency.

- If you are hospitalized in an out-of-network hospital, you will be transferred to an in-network hospital when medically feasible, with any ground ambulance charges reimbursed at the in-network level of benefits. If you decline to be transferred, coverage will be provided under the out-of-network benefit level.

Non-Emergency care worldwide is covered as follows:

- Non-Emergency services received in an in-network hospital Emergency room will be covered at the applicable in-network benefit.
- Non-Emergency services received in an out-of-network hospital Emergency room will be covered at the applicable out-of-network benefit.

Follow-up care worldwide is covered as follows:

- Follow-up care that results from a Medical Emergency while on travel outside the United States will be covered at the out-of-network level of benefit.
- Follow-up care that results from a Medical Emergency while on travel within the United States will be covered at the in-network level of benefits only if the place of care is not located within 30 miles of any in-network provider. Expenses for healthcare services that you should have received before leaving the Service Area or that could have been postponed safely until your return home are eligible for coverage at the out-of-network benefit level.

Note: If you are on Sandia-authorized business travel, you may be eligible to have Emergency and/or non-Emergency services covered at the in-network level of benefits. Contact the UHC Onsite Advocate for details.

Employee Assistance Program (EAP)

IMPORTANT: Precertification to UBH is required. Refer to [Section 3: Accessing Care](#).

The Sandia Total Health Program covers up to eight visits (in-network only) per calendar year at no cost to the employee for assessment, referral, and follow-up counseling for employees and their covered dependents experiencing some impairment from personal concerns that adversely affects their day-to-day activities. Such concerns include, but are not limited to:

- Health
- Marriage
- Family
- Finances
- Substance Abuse
- Legal issues
- Stress

Note: Retirees, survivors, and LTD terminees and their covered dependents are not eligible for Employee Assistance benefits.

Eye Exam/Eyeglasses/Contact Lenses

The Sandia Total Health Program covers eye exams for non-refractive care due to Sickness or Injury of the eye such as conjunctivitis, diabetic retinopathy, glaucoma, and cataracts. An initial pair of contact lenses or glasses when required due to the loss of a natural lens or cataract surgery is allowed. Employees and their covered dependents that are enrolled in the Sandia Vision Care Program are eligible to receive services related to refractive care under that program. Refer to the Preventive Care benefits in this section for information on vision screenings.

Family Planning

Family planning services are covered as follows:

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

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

Genetic Testing

The Sandia Total Health Program covers Medically Necessary genetic testing. Examples of covered genetic tests include testing related to breast and ovarian cancer. Genetic testing for breast cancer is covered under Preventive Care. Refer to the Exclusions section for information on what is excluded under genetic testing/counseling.

New requirement for members to obtain prior authorization Genetic testing – BRCA (breast cancer susceptibility).

Hearing Aids/Exam

The Plan will cover one (1) hearing aid per hearing-impaired ear every thirty-six (36) months for dependent children under the age of 21. This coverage shall include fitting and dispensing services, including providing ear molds as necessary to maintain optimal fit, provided by a licensed audiologist, a hearing aid dispenser or a physician.

For members over the age of 21, hearing aid(s) are covered ONLY if the hearing loss resulted from an illness or injury.

Hearing aid testing, repair and battery purchase are not covered. Refer to the Preventive Care benefits in this section for information on hearing screenings.

Home Healthcare Services

IMPORTANT: Prior Authorization to Personal Health SupportSM is required. Refer to [Section 3: Accessing Care](#).

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

- Ordered by a physician
- Provided by or supervised by a registered nurse in your home
- Not considered Custodial Care in nature
- Provided on a part-time, intermittent schedule when skilled home healthcare is required

Hospice Services

IMPORTANT: Prior Authorization to Personal Health SupportSM is required. Refer to [Section 3: Accessing Care](#).

Hospice care is covered as follows:

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

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

Infertility Services

In general, the Sandia Total Health Program pays benefits for infertility services and associated expenses for the diagnosis and treatment of an underlying medical condition that causes infertility, when under the direction of a physician.

A maximum lifetime benefit of \$30,000 per Covered Member is allowed for infertility treatments. This maximum is accumulated from any expenses related to infertility treatment paid following a confirmed diagnosis of infertility. Expenses for infertility services incurred without a diagnosis of infertility will not be reimbursed. There are limitations to eligible procedures (refer to [Section 8: What's Not Covered – Exclusions](#) for more information).

The maximum lifetime benefit does not include expenses related to diagnosing infertility, testing relating to determining the cause of infertility or the diagnosis and treatment of an underlying medical condition (e.g., endometriosis) that causes infertility. However, testing and treatments after a confirmed diagnosis of infertility will be applied to the \$30,000 lifetime limit such as:

- Medically Necessary laparoscopies and ultrasounds
- Artificial insemination
- In Vitro Fertilization
- Gamete intrafallopian transfers (GIFT)
- Zygote intrafallopian transfers (ZIFT)
- Embryo transplantation
- Laparoscopies for egg retrieval
- Purchase of sperm, if billed separately
- Limited donor expenses for egg donor (only the same charges that would be eligible to extract the egg from a covered employee are allowed for the donor; prescription medications taken by a donor are not allowable charges)
- Storing and preserving embryos for up to two years

Prescription Drugs for Infertility Treatments

Prescription drugs related to infertility are covered under the Prescription Drug Program with a prior authorization. Prescription drugs obtained through the Prescription Drug Program and used for infertility treatment may require a diagnosis of infertility. The cost of these drugs is not applied to the \$30,000 infertility limit if received through the Prescription Drug Program.

If the prescription drug or device is provided by the physician and billed through the provider's office or facility charges, UHC will review the charge to determine eligibility for reimbursement. If categorized as an infertility treatment, the charges will be applied to the \$30,000 limit. These charges may also be applied to the appropriate Program Deductibles and Out-of-Pocket Limits. Coverage for prescriptions for donors is not covered.

Infusion Therapy

IMPORTANT: Prior Authorization to Personal Health SupportSM is required. Refer to [Section 3: Accessing Care](#).

Outpatient infusion services for immunoglobulin therapy for conditions including but not limited to severe asthma, bone marrow transplants and diabetes mellitus. UnitedHealthcare will review the medical necessity of the site of service (outpatient facility, physician office, home) in addition to prior authorization review for immunoglobulin infusion therapy.

Injections in Physician's Office

Injections in a physician's office are covered as follows:

- In-network:
 1. Allergy shots – 20% of Eligible Expenses, after the Deductible
 2. Immunizations/vaccines – no cost to you as outlined under the Preventive Care benefit in this section
 3. All other injections (e.g., cortisone, Depo-Provera, etc.) – 20% of Eligible Expenses, after the Deductible
- For out-of-network services, you pay 40% of Eligible Expenses, after the Deductible

Inpatient Care

IMPORTANT: Prior Authorization to Personal Health SupportSM is required. Refer to [Section 3: Accessing Care](#).

Inpatient services in a hospital are covered as follows:

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

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

Benefits for an Inpatient Stay in the hospital are available only when the Inpatient Stay is necessary to prevent, diagnose, or treat a Sickness or Injury.

If you are admitted to a hospital on an Emergency basis that is not in the network and services are covered, in-network benefits will be paid until you are stabilized. Once stabilized, you must be moved to a network hospital to continue in-network benefits. You may elect to remain in the out-of-network hospital and receive out-of-network benefits, as long as UHC/UBH confirms the treatment to be Medically Necessary.

Surgeries (resulting in an Inpatient Stay) performed outside the United States will be covered at the out-of-network level of benefits if they are considered a covered procedure.

Maternity Services

IMPORTANT: Newborn and Mother's Health Protection Act: Under federal law, mothers and their newborns that are covered under group health plans are guaranteed a stay in the hospital of not less than 48 hours following a normal delivery or not less than 96 hours following a cesarean section. Notification to Personal Health SupportSM is ONLY required if

your stay will be longer than 48 hours following a normal delivery or longer than 96 hours following a cesarean section. Refer to [Section 3: Accessing Care](#).

Maternity services are covered as follows:

- Initial visit to the physician to determine pregnancy status
- Pre-natal and post-natal visits
- Charges related to delivery
- Charges for newborn delivery services, paid as follows:
 1. Charges billed for well-baby care are paid under the newborn but at the mother's level of benefit, subject to her Deductible and Out-of-Pocket Limit (e.g., if mom has met her Out-of-Pocket Limits, well-baby charges will be reimbursed as if the newborn's Out-of-Pocket Limit was met as well)
 2. Charges billed for the newborn under any other non-well baby ICD-10 code are paid under the newborn and subject to the newborn's Deductible and Out-of-Pocket Limit

Note: The Sandia Total Health Program will pay for Covered Health Services for the newborn for the first 31 calendar days of life. This is regardless of the newborn's condition or whether you enroll the dependent within the applicable time frame as referenced in the [NTESS Health Benefits Plan for Employees Summary Plan Description](#) or the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#) for continued coverage. If you submit enrollment paperwork after the 31st calendar day but before the 61st calendar day of the birth, the coverage effective date will not be retroactive. For example, if you submit enrollment paperwork on the 41st calendar day after birth, the Plan will cover the first 31 days and 41st day and beyond. The member will be responsible for any charges incurred between the 32nd and 40th day. This does not apply to third generation dependents such as grandchildren.

The Sandia Total Health Program will pay for maternity services for you, your covered spouse and your covered dependent children.

Licensed birthing centers are covered to include charges from the birthing center, physician, midwife, surgeon, assistant surgeon (if Medically Necessary), and anesthesiologist. Benefits for birthing services rendered in the home will be paid according to the network status of the physician with whom the licensed nurse midwife is affiliated. If the licensed nurse midwife is not affiliated with a physician and is not a part of the network, reimbursement will be paid on an out-of-network level. If you are admitted to hospital, you must notify Personal Health SupportSM within two business days or as soon as reasonably possible. Refer to [Section 3: Accessing Care](#), for more information.

Refer to the [Preventive Care](#) section for information on preventive services related to maternity.

Healthy Pregnancy Program

The voluntary Healthy Pregnancy Program offers free personal support through all stages of pregnancy and delivery. This Program is offered at no cost to you. To enroll, call 888-246-7389 between 8 a.m. and 10 p.m. MST, Monday through Friday. If you or your covered dependents are enrolled in this Program, you can get valuable educational information and advice. You or your covered dependent is encouraged to enroll within the first 12 weeks of pregnancy; however, you can enroll at any time, up to your 34th week.

When you call to enroll, a maternity nurse will fill out a pregnancy assessment with you over the telephone. The maternity nurse will review your completed assessment and determine if you have special pregnancy needs. If you or your dependent is identified as a mother-to-be with special health needs, the Program offers additional resources to help you.

This Program offers:

- Maternity nurses on duty 24 hours a day
- A free copy of The Healthy Pregnancy Guide
- A phone call from a maternity nurse halfway through the pregnancy to see how things are going
- A phone call from a nurse approximately four weeks postpartum to provide information on topics such as infant care, feeding, nutrition, and immunizations
- A copy of an available publication, for example, Healthy Baby Book, which focuses on the first two years of life

Medical Supplies

Certain medical supplies are covered, to include, but not limited to:

- Ostomy supplies
- Six pair or twelve compression stockings
- Aero chambers, aero chambers with masks or nebulizers (you can obtain these either under the medical benefits or the Prescription Drug Program but not both)
- Lancets, alcohol swabs, diagnostic testing agents, syringes, Novopen and insulin auto-injectors, and allergic Emergency kits can be obtained under the prescription drug benefits (refer to [Section 7: Prescription Drug Program](#)).

Nutritional Counseling

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

- Diabetes mellitus

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

Diet counseling for adults at higher risk for chronic diseases is covered under the preventive benefits. Refer to the [Preventive Care](#) section.

Obesity Surgery

IMPORTANT: Prior Authorization to Personal Health SupportSM is required. Refer to [Section 3: Accessing Care](#).

Surgical treatment of morbid obesity received on an inpatient basis provided all the following are true:

Body Mass Index (BMI) of 35 to 39.9 with one or more obesity-related co-morbid medical conditions OR BMI equal or greater than 40 and demonstration that dietary attempts at weight control have been ineffective and the individual is 18 years of age or older or has reached full expected skeletal growth. Documentation of a structured diet program includes physician or other healthcare provider notes and/or diet or weight loss logs from a structured weight loss program for a minimum of six (6) months.

Office Visits

The following services provided in the physician's office are covered as follows:

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

- Radiation therapy
- Additional requirement for members to obtain prior authorization for intensity modulated radiation therapy

Organ Transplants

IMPORTANT: UHC provides you with access to designated United Resource Networks provider through the Transplant Resource Services Program. It is not mandatory that you receive services through this Program, but if you do you may be eligible for additional benefits. Prior Authorization to Personal Health SupportSM or the Transplant Resource Services Program is required as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed). Refer to [Section 3: Accessing Care](#).

Benefits are available to the donor and the recipient when the recipient is covered under the Sandia Total Health. The transplant must meet the definition of a Covered Health Service and cannot be Investigational, Experimental, or Unproven. Examples of transplants for which the Program will pay for include but are not limited to:

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

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

Outpatient Surgical Services

Outpatient Surgery and related services are covered as follows:

- Facility charge

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

Benefits for professional fees are described under [Professional Fees for Surgical Procedures](#) in this section. Surgeries performed outside the United States will be covered at the out-of-network level of benefits if they are considered a covered procedure.

Members receiving diagnostic cardiac catheterization, electrophysiology implant, and sleep apnea surgeries must obtain Prior Authorization.

Prescription Drugs (other than those dispensed by Express Scripts)

Enteral nutrition/nutritional supplements/prescription drugs under UHC are covered as follows:

- Enteral nutrition/nutritional supplements for:
 1. Diagnosis of dysphagia (difficulty swallowing)
 2. As the sole source of nutrition
 3. In cases of the genetic disorder of Phenylketonuria (PKU)
 4. In cases of RH factor disorders
 5. Terminal cancer
- Intravenous medications
- Medication that is dispensed and/or administered by a licensed facility or provider, such as a hospital home healthcare agency, or physician’s office, and the charges are included in the facility or provider bill

Note: Medication obtained through a mail order service is not eligible for reimbursement under UHC. Please check [Section 7: Prescription Drug Program](#) for more information about the mail service program.

You can receive coverage for intravenous medications, enteral nutrition or nutritional supplements through either UHC or Express Scripts, but not both. Refer to [Section 7: Prescription Drug Program](#), for information on coverage of prescription drugs not mentioned above.

Preventive Care

Preventive care benefits are based on the recommendations of the U.S. Preventive Services Task Force (USPSTF) although other preventive care services may be covered as well. Your physician may recommend additional services based on your family or medical history. The Sandia Total Health Program will not cover all care that is preventive in nature but will cover certain services under the preventive care benefit.

See [Section 7: Prescription Drug Program](#) for information about covered preventive medications.

The Sandia Total Health Program will pay 100% of the Eligible Expenses in-network and 60% of the Eligible Expenses, after the Deductible, if done out-of-network for the services listed below.

IMPORTANT: To receive the preventive care benefit, the service must be submitted with a preventive ICD-10 diagnostic code. If the service is submitted with a non-preventive ICD-10 diagnostic code, it will be reimbursed up to the allowed non-preventive benefit amount (depending on network), and you may be required to pay the difference.

It is solely up to the provider as to whether the service is coded as preventive or diagnostic. Neither Sandia nor UHC can direct the provider to bill a service in any particular way. The issue as to how it is billed is between you and your provider.

Well Baby Care (0-2 years)

The Sandia Total Health Program will pay 100% of the Eligible Expenses in-network and 60% of the Eligible Expenses, after the Deductible, if done out-of-network for the following services:

- Routine physical exams (including height and weight) at birth, one, two, four, six, nine, 12, 15, 18, and 24 months
- Autism screening at 18 and 24 months
- Behavioral assessment as needed
- Congenital Hypothyroidism screening for newborns
- Development screening – surveillance throughout childhood as needed
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screenings as needed
- Hematocrit or hemoglobin screening as needed
- Hemoglobinopathies or sickle-cell screening for newborns
- Lead screening as needed
- Phenylketonuria (PKU) screening in newborns
- Thyroid screen as needed
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening as needed

Refer to the [Immunizations/Vaccines](#) section for information on these covered services.

Well Child Care (3-10 years)

The Sandia Total Health Program will pay 100% of the Eligible Expenses in-network and 60% of the Eligible Expenses, after the Deductible, if done out-of-network for the following services:

- One routine physical/annual exam (including height, weight, and body mass index measurements) is allowed each calendar year, regardless of the date of the previous routine physical/annual exam, and no more frequently than one per calendar year. Allowable exams include routine preventive physicals, including annual exams and sports physicals.
- Behavioral assessment as needed
- Development screening — surveillance throughout childhood as needed
- Dyslipidemia screening for children at higher risk of lipid disorders
- Hearing screenings as needed
- Hematocrit or hemoglobin screening as needed
- Lead screening as needed
- Obesity screening and counseling as needed
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening as needed

Refer to the [Immunizations/Vaccines](#) section for information on these covered services.

Well Adolescent Care (11-18 years)

The Sandia Total Health Program will pay 100% of the Eligible Expenses in-network and 60% of the Eligible Expenses, after the Deductible, if done out-of-network for the following services:

- One routine physical/annual exam (including height, weight, and body mass index measurements) is allowed each calendar year, regardless of the date of the previous routine physical/annual exam, and no more frequently than one per calendar year. Allowable exams include routine preventive physicals, including annual exams and sports physicals.
- Alcohol and drug use assessment as needed
- Behavioral assessment as needed
- Chlamydia infection screening as needed
- Development screening — surveillance throughout childhood as needed
- Dyslipidemia screening for children at higher risk of lipid disorders

- Hematocrit or hemoglobin screening as needed
- HIV screening as needed for adolescents at higher risk
- Lead screening as needed
- Obesity screening and counseling as needed
- Rubella screening (once per lifetime)
- Sexually transmitted infection prevention counseling as needed for adolescents at higher risk
- Tuberculin testing for adolescents at higher risk of tuberculosis
- Vision screening as needed

Refer to the [Immunizations/Vaccines](#) section for information on these covered services.

Well Adult Care (19 and older)

The Sandia Total Health Program will pay 100% of the Eligible Expenses in-network and 60% of the Eligible Expenses, after the Deductible, if done out-of-network for the following services:

- One routine physical/annual exam (including height, weight, and body mass index measurements) is allowed each calendar year, regardless of the date of the previous routine physical/annual exam, and no more frequently than one per calendar year. Allowable exams include routine preventive physicals, including annual exams and sports physicals.
- Abdominal aortic aneurysm one-time screening for men between the ages of 65 and 74 who have ever smoked
- Alcohol misuse screening and counseling as needed
- Blood pressure screening as needed
- Breast Cancer (BRCA) testing for women at higher risk (UHC will require pre-service genetic counseling prior to testing for the BRCA1 or BRCA2 gene mutations)
- Breast cancer chemoprevention counseling for women at higher risk
- Breast-feeding Support, Supplies and Counseling for women who are lactating
- Chlamydia infection screening as needed
- Contraception Methods and Counseling - The new requirement covers prescribed FDA-approved contraception methods, sterilization procedures and patient education and counseling for all women with reproductive capacity without cost-share. Condoms and spermicidal agents, for example, are not covered under the health reform law because they are available without a prescription. In addition, the law only covers

women's contraception, so male contraception and sterilization are not included in preventive care services benefits.

- Depression screening as needed
- Domestic Violence Screening and Counseling - Annual screening and counseling for interpersonal and domestic violence is covered at no cost at age-appropriate preventive visits including risk identification and guidance for risk reduction. Domestic violence screening is included in the wellness examination codes provided under preventive care services benefits.
- Diet counseling for adults at higher risk for chronic disease
- Gestational Diabetes Screening
- Gonorrhea screening for women at higher risk
- HIV screening and counseling as needed for adults at higher risk
- HPV DNA Testing - High-risk human papillomavirus (HPV) DNA testing in women begin at 30 years of age, and need not occur more frequently than every three years.
- Obesity screening and counseling as needed
- Rubella screening (once per lifetime)
- Sexually transmitted infection prevention counseling as needed for adults at higher risk; counseling and screening for human immunodeficiency virus for *all* sexually active women, not just women at risk.
- Syphilis screening as needed for adults at higher risk
- Tobacco use screening as needed and cessation interventions for tobacco users
- Well woman exam annually

Refer to the following sections for more information on these covered services:

[Immunizations/Vaccines](#), [Laboratory Services](#), [Cancer Screening Services](#), [Pregnancy-Related Preventive Care Services](#), and [Bone Density Testing \(Osteoporosis screening\)](#).

Immunizations/Vaccines

The Sandia Total Health Program will pay 100% of the Eligible Expenses in-network and 60% of the Eligible Expenses, after the Deductible, if done out-of-network for non-travel related immunizations, vaccines, and flu shots. Flu shots and some immunizations/vaccines are available at no cost to you at an in-network retail pharmacy. Immunizations for personal travel will pay 80% of the Eligible Expenses in-network and 60% of the Eligible Expenses, after the deductible.

IMPORTANT: Immunizations for Sandia-business-related travel must be given at the Sandia's onsite clinic; however, if Sandia's onsite clinic directs the employee to obtain immunizations offsite for Sandia-business-related travel, you will be reimbursed at 100% of

the charge, regardless of whether you obtain the immunizations in- or out-of-network. Contact the UHC Onsite Advocate at: 505-844-0657 if this exception is required to ensure proper reimbursement.

Laboratory Services

The Sandia Total Health Program will pay 100% of the Eligible Expenses in-network and 60% of the Eligible Expenses, after the Deductible, if done out-of-network, for the following laboratory services for those age 19 and older:

- Complete blood count (CBC) with differential, which includes white blood count, red blood count, hemoglobin, hematocrit, platelet, mcv, mchc, rdw. Differential includes neutrophils, lymphocytes, monocyte, eosinophil, basophile, absolute neutrophil, absolute lymphocyte, absolute monocyte, absolute eosinophile, absolute basophile, diff type, platelet estimate, red blood cell morphology.
- Complete urinalysis, which includes source, color, appearance, specific gravity, urine PH, protein, urine glucose, urine ketones, urine bilirubin, blood, nitrate, urobilinogen, leukocyte esterase, red blood count, white blood count, squamous epithelial, calcium oxylate
- Complete metabolic profile, which includes sodium, potassium, chloride, CO₂, anion, glucose, bun, creatinine, calcium, total protein, albumin, globulin, bilirubin total, alkphos, asp, alt
- Diabetes screening, which includes a two-hour postprandial blood sugar and HbA1c
- Thyroid screening, which includes free T4 and TSH
- Lipid panel, which includes triglycerides, total cholesterol, HDL, and calculated LDL cholesterol

As ordered by the physician, you are entitled to one of each of the above category once every calendar year. If the physician orders one or more components within one of the above categories but not the complete set, and it is submitted with a preventive code, it will still be eligible for reimbursement under the preventive benefit.

Cancer Screening Services

The Sandia Total Health Program will pay 100% of the Eligible Expenses in-network and 60% of the Eligible Expenses, after the Deductible, if done out-of-network, for the following services:

Service	Allowed Frequency	Allowable Age
Pap Test	As needed	Age 11 and older
Prostrate Antigen Test	Annual	Upon turning 50
Mammogram*	Baseline, Annual	Between age 35-39, upon turning 40
Fecal Occult Blood Test	Annual	Upon turning 50

Service	Allowed Frequency	Allowable Age
Sigmoidoscopy**	Once every five years	Upon turning 50
Colonoscopy**	Once every ten years	Upon turning 50
Barium Enema**	Once every five years	Upon turning 50

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

**You are entitled to the following:

- A sigmoidoscopy once every five years, OR
- A colonoscopy once every 10 years, OR
- A sigmoidoscopy or colonoscopy under age 50 or more frequently if you have an immediate family history (mother, father, sister, brother only) of colorectal cancer or you have a personal history of colonic polyps. Polyp removal during a preventive colonoscopy will be covered under the preventive colonoscopy benefit.

**A barium enema once every five years in lieu of a colonoscopy or sigmoidoscopy

Note: From time to time, Sandia will sponsor mobile mammogram screenings at Sandia or in the community through this Program. Screenings are available to Covered Members age 35 and above (or for high risk women as outlined above). In addition, the annual requirement is waived for these screenings.

Pregnancy-Related Preventive Care Services

The Sandia Total Health Program will pay 100% of the Eligible Expenses in-network and 60% of the Eligible Expenses, after the Deductible, if done out-of-network, for the following pregnancy-related services, on an as needed basis:

- Multiple marker screening between weeks 15 and 18 for pregnant women age 35 and older
- Serum alpha-fetoprotein between weeks 16 and 18 based on personal risk factors
- Chorionic villus sampling before week 13 or amniocentesis between weeks 15 and 18 in women who are 35 and older and at risk for passing on certain chromosomal disorders
- Hemoglobiopathy screening if at risk for passing on certain blood disorders
- Screening for gestational diabetes between 24 and 28 weeks
- Screening for group B strep between 35 and 37 weeks
- Anemia screening on a routine basis
- Bacteriuria urinary tract or other infection screening
- Breast feeding interventions to support and promote breast feeding

- Breast Pumps - For women who are lactating. Benefits are only available if breast pumps are obtained from a DME provider, Hospital or Physician. Refer to DME section.
- Hepatitis B screening at first prenatal visit
- Rh incompatibility screening and follow-up testing for women at higher risk
- Syphilis screening
- Tobacco use screening and counseling as needed

Bone Density Testing (Osteoporosis screening)

The Sandia Total Health Program will pay 100% of the Eligible Expenses in-network and 60% of the Eligible Expenses, after the Deductible, if done out-of-network, for bone density testing once every three years upon turning age 50.

Professional Fees for Surgical Procedures

The Sandia Total Health Program pays professional fees for surgical procedures and other medical care received from a physician in a hospital, Skilled Nursing Facility, inpatient rehabilitation facility, or Outpatient Surgery facility.

The Program will pay the following surgical expenses:

- Only one charge is allowed for the operating room and for anesthesia.
- A surgeon will not be paid as both a co-surgeon and an assistant surgeon.
- Expenses for certified first assistants are allowed.
- Incidental procedures are those services carried out at the same time as a more complex, primary procedure. The incidental procedure may be a part of the primary procedure and require little or very little additional time and resources; therefore, they are usually not covered.
- A surgical procedure that is performed and not considered incidental to the primary procedure will be reimbursed at half of the allowable. For example: When bilateral surgical procedures are performed by one or two surgeons, the Sandia Total Health Program will consider the first procedure at the full allowed amount, and the second procedure will be considered at half of the allowed amount of the listed surgical unit value.
- Foot surgery – for a single surgical field/incision or two surgical fields/incisions on the same foot, the Program will allow the full amount for the procedure commanding the greatest value; half of the full amount for the second procedure; half of the full amount for the third procedure; and a quarter of the full amount for each subsequent procedure. Also, if procedure 11721 is billed in conjunction with 10056 and 10057, these will be reimbursed separately without bundling when billed with a medical diagnosis.

Prosthetic Devices/Appliances

The Sandia Total Health Program covers prosthetic devices and appliances that replace a limb or body part or help an impaired limb or body part work. Examples include:

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

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

Benefits are provided for the replacement of each type of prosthetic device once every five calendar years. At UHC's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement, if the device or appliance breaks, or is otherwise irreparable, or when a change in your medical condition occurs sooner than the five-year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part. If the prosthetic device or appliance is lost or stolen, the Sandia Total Health Program will not pay for replacement unless the device or appliance is at least five years old.

Reconstructive Procedures

IMPORTANT: Prior Authorization to Personal Health SupportSM is required. Refer to [Section 3: Accessing Care](#).

The Sandia Total Health Program covers certain Reconstructive Procedures where a physical impairment exists and the expected outcome is a restored or improved physiological function for an organ or body part.

Improving or restoring physiological function means that the organ or body part is made to work better. The fact that you may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored. There may be times when the primary purpose of a procedure is to make a body part work better; however, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Upper eyelid surgery, for example, is sometimes performed to improve vision, which is considered a Reconstructive Procedure, but in other cases, improvement in appearance is the primary

intended purpose, which is considered a Cosmetic Procedure and is not covered. Refer to [Section 8: What's Not Covered – Exclusions](#) for more information.

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

Rehabilitation Services (Outpatient Therapies)

Outpatient rehabilitation services for the following types of therapy are covered:

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

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

Speech, physical, and occupational therapies rendered for developmental Disorders are covered until the patient is at a Maintenance level of care as determined by UHC.

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

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

IMPORTANT: Prior Authorization to Personal Health SupportSM is required. Refer to [Section 3: Accessing Care](#).

Facility services for an Inpatient Stay in a Skilled Nursing Facility or inpatient rehabilitation facility are covered. Benefits include:

- Services and supplies received during the Inpatient Stay
- Room and board in a semi-private room (a room with two or more beds). The Sandia Total Health Program will pay the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice as determined by UHC.

Benefits are available when Skilled Nursing and/or inpatient rehabilitation facility services are needed daily. Benefits are also available in a Skilled Nursing Facility or inpatient rehabilitation facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a hospital.

The intent of skilled nursing is to provide benefits if, as a result of an Injury or Sickness, you require:

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

The Program does not pay benefits for Custodial Care, even if ordered by a physician.

Temporomandibular Joint (TMJ) Syndrome

The Sandia Total Health Program covers diagnostic and surgical treatment of conditions affecting the temporomandibular joint, including splints, when provided by or under the direction of a physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Urgent Care

The Program will cover Urgent Care as follows:

- If you receive care at an in-network Urgent Care Facility within the United States, you will be reimbursed under the in-network level of benefits.
- If you receive care at an out-of-network Urgent Care Facility within the United States, you will be reimbursed under the out-of-network level of benefits. If you are traveling within the United States and there are no in-network facilities available within a 30-mile radius, your claim will be processed at the in-network benefit level.
- If you are traveling outside the United States, your claim will be processed at the in-network benefit level.
- Follow-up care while traveling outside the United States will be covered at the out-of-network level of benefit.
- Follow-up care while traveling within the United States will be covered at the applicable in-network level of benefits only if the place of care is not located within 30 miles of any in-network provider.

Section 7. Prescription Drug Program

The Prescription Drug Program, although part of the Sandia Total Health Program, is administered separately by Express Scripts. For information on filing claims, claim denials, and appeals, refer to [Section 10: How to File a Claim](#) and [Section 11: How to File an Appeal](#).

IMPORTANT: All claims must be submitted within one year after the date of service in order to be eligible for consideration of payment. This one-year requirement will not apply if you are legally incapacitated.

The following chart summarizes your Coinsurance responsibility as well as coverage for purchases under the Smart90 Retail & Mail-Order Program and the Express Scripts network and out-of-network retail pharmacies.

Express Scripts Smart90 Retail/Mail-Order Pharmacy (for maintenance prescription drugs)	Express Scripts Network Retail Pharmacies	Out-of-Network Retail Pharmacies
Refer to Specialty Drug Management Program for information on coverage for specialty drugs.		
Coinsurance of 20% of Walgreens Pharmacy/mail order discount price with a \$12.50 minimum and \$25 maximum for generic prescription drugs	Coinsurance of 20% of retail discount price with a \$5 minimum and \$10 maximum for generic prescription drugs	50% reimbursement
Coinsurance of 30% of Walgreens Pharmacy/mail order discount price with a \$75 minimum and \$112.50 maximum for preferred brand name prescription drugs	Coinsurance of 30% of retail discount price with a \$30 minimum and \$45 maximum for preferred brand name prescription drugs	50% reimbursement
Coinsurance of 40% of Walgreens Pharmacy/mail order discount price with a \$125 and \$187.50 maximum for non-preferred brand name prescription drugs	Coinsurance of 40% of retail discount price with a \$50 minimum and \$75 maximum for non-preferred brand name prescription drugs	50% reimbursement
Maximum of 90-day supply	Maximum of 30-day supply	Maximum of 30-day supply File claims with Express Scripts
Out-of-Pocket Limit is \$1,500 per person per year and \$5950 for family. There is not an Out-of-Pocket limit for out-of-network prescription drugs or Smart90 eligible prescription drugs purchased outside of the program after two courtesy fills.		Out-of-Pocket Limit does not apply
<p>If a multi-source generic drug is reclassified as a single source brand name, the Coinsurance will change from 20% to 30% or 40% with the applicable minimum and maximum copays.</p> <p>Coinsurance does not apply to the Sandia Total Health Program medical Deductible and/or Out-of-Pocket Limit.</p> <p>Reimbursement for prescriptions purchased outside the United States will be reimbursed at the applicable retail Coinsurance, limited to a maximum of a 30-day supply.</p>		

Eligibility

If you are eligible for coverage under the Sandia Total Health Program, then you are eligible for the Prescription Drug Program. If you have primary prescription drug coverage under another group healthcare plan or Medicare, you are not eligible to use the Mail-Order Program or purchase drugs from retail network pharmacies at the Coinsurance benefit.

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

Covered Prescriptions

IMPORTANT: FDA approval of a drug does not guarantee inclusion in the Prescription Drug Program. New drugs may be subject to review before being covered under the Prescription Drug Program or may be excluded based on program guidelines and policies.

Only licensed providers authorized to prescribe medications in the United States may issue your prescription(s). To be covered, the prescription must be considered Medically Necessary. Consideration of medical Necessity occurs when a clinician's request falls outside standard criteria. Medical Necessity is a case-by-case assessment based upon substantiated justification as documented by the treating healthcare professional. It must be in accordance with standard medical practice and clinical appropriateness to include but not limited to off-label and non-indicated uses. The Prescription Drug Program covers the following categories of drugs:

- Federal Legend Drugs – A medicinal substance that bears the legend “Caution: Federal Law prohibits dispensing without a prescription”
- State Restricted Drugs – A medicinal substance that, by state law, may be dispensed by prescription only
- Compounded Medications – A compounded prescription in a customized dosage form that contains at least one federal legend drug. Contact Express Scripts before you fill your prescription to confirm if your compound is covered.
 - The U.S. Food and Drug Administration (FDA) defines a compound medication as one that requires a licensed pharmacist to combine, mix or alter the ingredients of a medication when filling a prescription. Pharmacies must submit all ingredients in a compound prescription as part of the claim for both online and paper claim submissions. All ingredients submitted with the compound prescription claim must be covered and at least one of the ingredients must require a physician's prescription for reimbursement.
 - Prescriptions containing certain ingredients (such as, over-the-counter (OTC) products, bulk powders, kits, solid dosage forms, and proprietary bases) when compounded for dispensing are **not** covered through the prescription benefit.

Investigational drugs are not FDA approved. If the compound includes an investigational drug, the compound will not be covered.

- The following prescription devices/supplies:
 1. Insulin auto-injectors
 2. Lancet auto-injectors
 3. Glucagon auto-injectors
 4. Epi-Pens
 5. Aero-chambers, aero-chambers with masks, nebulizer masks (you may receive coverage under either the medical portion with UHC or the Prescription Drug Program but not both)

Note: Medicare covers lancets and test strips. Continuous Glucose Monitoring Systems (CGMS), Insulin Pumps, and supplies for CGMS and Insulin Pumps are not covered under the Prescription Drug Program. Please refer to [Section 3: Accessing Care](#) for coverage information.

- The following over-the-counter (OTC) medications/supplies:
 1. Nutritional supplements (requires a Prior Authorization)
 2. Insulin and Diabetic Supplies – Supplies, including lancets, alcohol swabs, ketone test-strips (both blood and urine), and syringes, can be purchased at the appropriate Coinsurance level, in-network with a prescription, or in-network without a prescription by paying the full price and submitting the claim to Express Scripts for reimbursement. (You will be reimbursed at the appropriate Coinsurance level.) The Mail-Order Program is also available for insulin and diabetic supplies purchased with a prescription. **Note:** Medicare covers lancets and test strips.

Note: The Prescription Drug Program covers immunizations obtained and/or administered at retail network pharmacies at no cost to you. In addition, Express Scripts maintains a program in which certified pharmacists within the US are licensed to prescribe and administer certain vaccinations. To inquire about this Program, contact Express Scripts at 877-817-1440.

Covered Preventive Medications

The Sandia Total Health Program will pay 100% of the cost at a retail network pharmacy for the following medications:

- One aspirin per day (generic only) to prevent cardiovascular disease for age 45 to 79 as follows:
 - Aspirin 81 mg to 325 mg
 - Aspirin chew 81 mg to 325 mg

- Aspirin delayed release 81 mg to 325 mg
- Aspirin dispersible tab 81 mg
- One aspirin per day (generic only) to prevent Preeclampsia for women age 55 or younger as follows:
 - Aspirin 81 mg
 - Aspirin chew 81 mg
 - Aspirin delayed release 81 mg
 - Aspirin dispersible tab 81 mg
- Bowel Preparation Agents
 - Generic only
 - Adults; ≥ 50 and ≤ 75 years of age.
 - Fill Limit: 2 prescriptions per 365 days
- Oral fluoride supplementation (prescription only) for children between the age of six months and five years whose primary water source is deficient in fluoride as follows:
 - Sodium fluoride tab 0.5 mg
 - Sodium fluoride chew tab 0.25 mg to 0.5 mg
 - Sodium fluoride solution
- Folic acid tab 0.4 mg and 0.8 mg (one per day) for women age 50 or younger who may become pregnant
- Gardasil – 3 doses over a 6 month period – females age 9 to 26
- Hepatitis A and B vaccine
- Influenza vaccine
- Meningococcal vaccine
- Pneumococcal vaccine – as needed
- Low/moderate dose of a statin (generic only) to prevent cardiovascular disease for adults age 40-75 as follows:
 - Atorvastatin 10 – 20mg
 - Fluvastatin IR and XL 20 - 80mg
 - Lovastatin 10 - 40mg
 - Pravastatin 10 - 80mg
 - Simvastatin 5 – 40mg
 - Rosuvastatin 5 – 10mg

- Tobacco cessation products for ages 18 and older as follows:
 - Nicotrol Inhaler and Nasal Spray (refer to Prescriptions with Quantity Limits)
 - Zyban
 - Chantix
 - Nicotine patches
- Varicella (chicken pox)
- Women’s Contraceptives:
 - Generic
 - Single source (SS)
 - Multiple source (MS)
 - Dispense as Written per Physician (DAW1)
 - Brand single source
 - Barrier contraceptive method – diaphragms/cervical caps
 - Hormonal contraceptive methods – oral, transdermal, intravaginal Injectable Hormonal contraceptives
 - Emergency contraceptive method – e.g. Plan B and Ella
 - Implantable medications – e.g. Implanon
 - Intrauterine contraceptives – e.g. Mirena, Skyla
- Zoster (Zostavax) / shingles – adults age 60 and older
- Shingrix / shingles – adults age 50 and older

Note: All preventive medications require a prescription, whether they are over the counter or not.

National Preferred Formulary

The Sandia Total Health Program utilizes the Express Scripts’ National Preferred Formulary (Formulary). Preferred Drugs are selected according to safety, efficacy (whether the drug works for the indicated purpose), therapeutic merit (how appropriate the drug is for the treatment of a particular condition), current standard of practice, and cost. Non-Preferred drugs are also on the Formulary, but at a higher cost sharing tier. Drugs that are excluded from Formulary are not covered by the prescription drug program unless approved through a Formulary exception process managed by Express Scripts. If approved through the process, the non-preferred copay applies.

The Formulary is the same for both the Mail-Order Pharmacy and the retail network pharmacies and is comprehensive for all major categories of acute and maintenance

medications. To find out the Formulary status of a drug, you can either call Express Scripts at 877-817-1440 or look on the web at www.express-scripts.com (enter the member ID# from your ID card, your date of birth and “Sandia” in the Rx Group Number field).

If, for some reason, you are unable to take any of the preferred alternatives, you, your pharmacist or your physician can initiate an exception request by contacting Express Scripts directly and requesting a Prior Authorization (PA) for the medication. Refer to the information below for PA information. Express Scripts will contact your doctor and request the information necessary for a non-preferred brand name drug. Express Scripts will review the letter and make the decision as to whether you will be able to receive the non-preferred drug for the preferred brand name Coinsurance amount, or excluded drugs at the non-preferred Coinsurance amount.

Prescriptions Requiring Prior Authorization

A Prior Authorization (PA) is a clinical program that ensures appropriate use of prescription medications. You, your pharmacist or your physician can initiate a PA for the medication by contacting Express Scripts Prior Authorization department directly at 800-417-8164 and requesting a PA for the medication. Medications subject to a PA require a clinical review and pre-approval from the Express Scripts Prior Authorization Team before they can qualify for coverage under this Program. Medications requiring Prior Authorization are subject to change. Therefore, if you have questions about a particular drug, please contact Express Scripts customer service at 877-817-1440.

Prescriptions Subject to Step Therapy Program

Step Therapy (Step) – Step Therapy is a program in which certain drug classes are organized in a set of “steps”, first line drugs used first prior to second line alternatives. Drug classes included in this program are subject to change. If you have questions about a particular drug or this program, please contact Express Scripts customer service at 877-817-1440. Prescriptions Subject to Quantity Limits.

Drug Quantity Management (DQM) – Drug Quantity Management (DQM) is a program in your pharmacy benefit that’s designed to make the use of prescription drugs safer and more affordable. It provides you with medicines you need for your good health and the health of your family, while making sure you receive them in the amount – or quantity – considered safe. Medications included in this program are subject to change. Therefore, if you have questions about a particular drug or this program, please contact Express Scripts customer service at 877-817-1440.

- Sleep Agents: 15 tabs/30 days or 45 tabs/90 days (limitation is waived if prescribed by a Sleep Specialist as deemed by Express Scripts)
- Erectile Dysfunction: 8 tabs/30 days or 24/90 days
- Revatio/Adcirca: 93 in 31 days

- Tussionex: 120 MI in 30 days
- Nicotrol Nasal Spray: 3 kits/30 days
- Tamiflu: 10 caps per year

Note: List of drugs subject to change.

Smart90 Retail Program

Express Scripts partners with Walgreens Pharmacy to offer the Smart90 Program. Smart90 is a program for members taking long-term prescriptions to receive them in a 90-day supply at lower cost than 30-day supply.

Smart90 offers two options to receive medications:

- Prescriptions may filled and delivered by Express Scripts Pharmacy Home Delivery, or
- Filled by a participating Walgreens Pharmacy

You can request that you provider submit an e-prescription for a 90-day supply of medication with exact information for daily dosage, strength, quantity (e.g., number of pills, inhalers, tubes), and number of refills to Walgreens Pharmacy or Express Scripts Pharmacy (any location) at the time of the appointment, if electronic prescribing is available. If medication is needed right away, request a second prescription of a 30-day supply be sent to a local in network pharmacy of your choice for pickup. Smart90 provides two courtesy months of refills at a 30-day supply.

If e-prescribing is not available, providers may also call in the prescriptions to Express Scripts at 888-327-9791. Prescriptions preferred to be filled at Walgreens Pharmacy can be called in our hand carried to any local Walgreens Pharmacy.

See the Mail Order Program below on more information about Home Delivery from Express Scripts Pharmacy.

Note: For medications that are eligible for the Smart90 Program, you will receive two courtesy months of refills at the retail coinsurance amount at any in-network retail pharmacy. However, if you do not elect one of the above options, you will be responsible to pay 100% of the cost of the prescription(s) afterwards. These costs do not apply to the prescription drugs Out-of-Pocket limit. The Smart90 Retail Program does not apply to controlled substances, narcotic medications, or specialty medications dispensed through Accredo Pharmacy. See Specialty Drug Management Program for more details.

Mail Service Program

Express Scripts partners with Express Scripts Pharmacy to offer a Mail Service Benefit. Express Scripts Pharmacy is a licensed pharmacy specializing in filling prescription drug orders for maintenance prescriptions. Maintenance prescription drugs are those taken routinely

over a long period of time for an ongoing medical condition. Let your physician know that you are planning to use the Mail Service Program and request a 90-day prescription (with up to three refills). Verify that the prescription specifies the exact information for daily dosage, strength, quantity (e.g., number of pills, inhalers, tubes), and number of refills.

Registered pharmacist and technicians are available 24 hours a day, seven days a week, at 877-817-1440, to answer medication-related questions. Prescriptions are delivered to your home. (You are not responsible for shipping and handling fees unless you request special shipping arrangements.) To obtain a maintenance prescription through the Mail Service Program, you pay the appropriate Coinsurance for each prescription up to a 90-day supply.

If you send in a prescription through the Mail Service Program and Express Scripts Mail Service does not carry the medication or if it is out of stock and Express Scripts Mail Service does not anticipate getting the medication in a timely manner, you will be able to receive a 90-day supply at a retail network pharmacy for the applicable mail-order Coinsurance. Contact Express Scripts at 877-817-1440 for assistance.

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

Steps for Ordering and Receiving Mail Order Prescriptions (other than Specialty Medications)

You can request that your provider submit an e-prescription for a 90-day supply of medication with exact information for daily dosage, strength, quantity (e.g., number of pills, inhalers, tubes), and number of refills to Express Scripts Pharmacy (any location) at the time of the appointment, if electronic prescribing is available. If medication is needed right away, request a second prescription of a 30-day supply be sent to a local in network pharmacy of your choice for pickup.

If e-prescribing is not available, providers may also call in the prescriptions to Express Scripts at 888-327-9791.

If you would prefer to mail in your original prescription, follow the steps for ordering and receiving below:

Step	Action	
1	Forms	Obtain a Express Scripts Mail Service Registration & Prescription Order Form from the Sandia website or www.express-scripts.com .
2	Ordering Original Prescriptions	Complete the Express Scripts Mail Service Registration & Prescription Order Form Attach your original written prescription (with your Member Identification number and address written on the back). Make sure your physician has written the prescription for a 90-day supply with applicable refills.

Step	Action	
		<p>Enclose the required Coinsurance using a check or money order, or complete the credit card section on the form.</p> <p>Mail all to Express Scripts Mail Service, PO Box 66568, St. Louis, MO 63166-9819. Your physician may also call in the prescription to Express Scripts at 888-327-9791.</p> <p>Note: If you need medication immediately, ask your doctor for two (2) separate prescriptions – one for a 30-day supply to be filled at a network retail pharmacy, and one to be filled by mail service. Wait and send in your mail service prescription two weeks after you fill your prescription at the retail network pharmacy to avoid any delays with your mail service prescription.</p>
3	Delivery	<p>Expect delivery to your home by first-class mail. A physical street address is needed. There are additional charges for requesting express shipping.</p>
4	Refills	<p>Refilling a mail service order prescription can be done by phone, mail, or through the web. It is recommended that you order three weeks in advance of your current mail service prescription running out.</p> <p>Refill-by-Phone: Call 877-817-1440 to order refills. You may use the automated refill system 24 hours a day. Customer service representatives are available Monday through Sunday 24/7</p> <p>Refill-by-Fax: Have your physician contact Express Scripts for the Fax Order Form. The physician (not you) must fax the number on the form. Note: Schedule II prescriptions cannot be faxed.</p> <p>Refill-by-Mail: Complete the Prescription Order Form (attached to the bottom of your customer receipt), making sure you adhere the refill label provided or write the prescription number in the space provided. Mail in the self-addressed, postage-required envelope.</p> <p>Refill through the Web: Go to www.express-scripts.com. Log on to this site. On the left hand side of your screen, select "Order Prescriptions". From there, follow the instructions to place your refill order. You will need to use one of the accepted credit cards for payment.</p> <p>Refill-by-Mobile App: Downloading the free app, log in with your Express-Scripts.com username and password. If you haven't yet registered with Express-Scripts.com, you can create a username and password right from the app – and use the same username and password to access the website.</p>

Brand-To-Generic Substitution

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

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

Many drugs are available in generic form. Generic drugs offer substantial cost savings over brand names; therefore, the Mail-Service Program has a generic substitution component. Unless your doctor has specified that the prescription be dispensed as written, your prescription will be filled with the least expensive acceptable generic equivalent when available and permissible by law. If you receive a generic medication in place of the brand name medication, and you want the brand name medication, you will need to obtain a new

prescription stating “no substitution” or “dispense as written” and resubmit it along with the required Coinsurance.

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

Retail Pharmacies

This section does not apply to Smart90 Retail Program eligible medications filled at a participating Walgreens Pharmacy.

Retail pharmacies are available if you need immediate, short-term prescription medications, and/or prescription medications that cannot be shipped through the mail.

Using the Network Retail Pharmacies

Express Scripts has contracted with specific retail pharmacies across the nation that will provide prescriptions to Sandia at discounted rates. These pharmacies are known as retail network pharmacies. To locate the pharmacy nearest you, call Express Scripts at 877-817-1440 or visit www.express-scripts.com.

To obtain a medication through a retail network pharmacy, you will need a written prescription from your physician. Present the prescription and your Express Scripts ID card to the pharmacist. The card is required to identify that you are covered under the Program in order to remit the appropriate Coinsurance

If you request a prescription to be filled in a retail network pharmacy for more than a 30-day supply, the pharmacist will fill only 30 days for the appropriate Coinsurance of 20%, 30%, or 40% and hold the rest as refills. When you need a refill, return to the pharmacy, pay another Coinsurance amount, and receive another maximum 30-day supply (or up to the amount prescribed by the physician).

Using the Out-of-Network Retail Pharmacies

If you choose to purchase a prescription through an out-of-network pharmacy, you will be reimbursed 50% of the cost for up to a 30-day supply. Any amounts over a 30-day supply will be denied. Refer to [Section 10: How to File a Claim](#).

Specialty Drug Management Program

Specialty medications must be purchased through the Express Scripts Specialty Pharmacy, Accredo Specialty Pharmacy (Accredo), in order to be eligible for coverage. Specialty drugs are prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic and often costly conditions such as cancer, hepatitis C, multiple sclerosis, rheumatoid arthritis, etc. To find out if your prescription falls into this category, call Express Scripts at 877-817-1440.

Under this Program, your prescription will be limited to a 30-day supply and will be subject to the retail Coinsurance level of benefits. Any amounts over a 30-day supply will be denied. There is no additional cost to you above your required Coinsurance. In addition to your medication, you will also receive the necessary supplies for administration such as alcohol swabs and syringes at no additional cost. The Specialty Pharmacy is staffed by experienced pharmacists who are specially trained in complex health conditions and the latest therapies to provide support, counseling and assistance with medication management.

Steps for Ordering and Receiving Specialty Prescriptions through Accredo:

Step	Action	
1	Ordering Original Prescriptions	Your physician submits the prescription for you directly to the Accredo Specialty Pharmacy by e-prescription, fax, telephone or mail. Your information is entered into the ordering system and a pharmacist reviews it for completeness and contacts your physician, if necessary.
2	Payment	Accredo will call you to confirm your insurance and to let you know what the Coinsurance will be. You must have a credit card on file. Accredo will bill the card you have on file for the applicable Coinsurance.
3	Delivery	Accredo will call you to schedule a delivery date. Expect delivery to your home (unless you made alternative shipping arrangements with Accredo directly) via overnight mail. Most orders ship via UPS or Federal Express for next day delivery.
4	Refills	Once enrolled, Accredo will call you prior to your next dose. However, if you have not received a phone call, please contact Accredo to avoid any disruption in your therapy. Accredo will confirm your information and schedule a delivery date at your convenience.

Section 8. What's Not Covered – Exclusions

Although the Sandia Total Health Program provides benefits for a wide range of Covered Health Services, there are specific conditions or circumstances for which the Sandia Total Health Program will not provide benefit payments. In general, any expense that is primarily for your convenience or comfort or that of your family, caretaker, physician, or other medical provider will not be covered. For additional limitations under the Prescription Drug Program, refer to [Section 7: Prescription Drug Program](#).

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

Exclusions	Examples
Administrative fees, penalties, and limits	Charges that exceed what the Claims Administrator determines are Eligible Expenses Insurance filing fees, attorney fees, physician charges for information released to claims administrator, and other service charges and finance or interest charges Amount you pay as a result of failure to contact UHC for Prior Authorization or precertification, including unauthorized care Employee Assistance Program services when you do not obtain precertification from UBH Charges incurred for services rendered that are not within the scope of a provider's licensure Charges for missed appointments
Ambulance	Non-Emergency ambulance services (e.g., home to physician for an office visit)
Behavioral Health Services	Behavioral health services that are considered to be at a maintenance level of care. Family therapy, including marriage counseling and bereavement counseling. Family therapy, marriage counseling, and bereavement counseling are covered for employees and their dependents only through the Employee Assistance Program Conduct disturbances unless related to a coexisting condition or diagnosis otherwise covered Educational, vocational, and/or recreational services as Outpatient procedures Biofeedback for treatment of diagnosed medical conditions Treatment for insomnia, other sleep disorders, dementia, neurological disorders, and other disorders with a known physical basis (certain treatments may be covered under medical portion of the Program) Treatment that is determined by UBH to be for your personal growth or enrichment Court-ordered placements when such orders are inconsistent with the recommendations for treatment of a UBH participating provider for mental health or UBH Services to treat conditions that are identified by the most current edition of the Diagnostic and Statistical Manual of Mental Disorders as not being attributable to a Mental Disorder Sex transformations Any services or supplies that are not Medically Necessary Custodial Care Pastoral counseling Developmental Care Treatment for caffeine or tobacco addictions, withdrawal, or dependence Aversion therapies Treatment for codependency

Exclusions	Examples
Behavioral Health Services (cont.)	<p>Non-abstinence-based or nutritionally-based treatment for Substance Abuse</p> <p>Services, supplies, or treatments that are covered benefits under the medical part of this Program</p> <p>Treatment or consultations provided via telephone</p> <p>Services, treatments, or supplies provided as a result of a Worker's Compensation law or similar legislation, or obtained through, or required by, any government agency or program, whether federal, state, or any subdivision, or caused by the conduct or omission of a third party for which you have a claim for damages or relief, unless you provide UBH with a lien against the claim for damages or relief in a form and manner satisfactory to UBH</p> <p>Non-organic erectile dysfunction (psychosexual dysfunction)</p> <p>Treatment for conduct and impulse control disorders, personality disorders, paraphilias (unusual sexual urges), and other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by UBH</p> <p>Services or supplies that:</p> <ul style="list-style-type: none"> • Are considered Investigational, Experimental, or Unproven drugs, devices, treatments, or procedures • Result from or relate to the application of such Investigational, Experimental, or Unproven drugs, devices, treatments, or procedures <p>Wilderness programs, boot camp-type programs, work camp-type programs, or recreational-type programs</p> <p>Services or supplies that are primarily for your education, training, or development of skills needed to cope with an Injury or Sickness</p> <p>Substance Abuse benefits for Class II dependents</p>
Biofeedback	Biofeedback is not a Covered Health Service
Congenital Heart Disease	<p>CHD services other than as listed below are excluded from coverage unless determined by United Resource Networks or Personal Health Support SM to be proven procedures for the involved diagnoses:</p> <ul style="list-style-type: none"> • Outpatient diagnostic testing • Evaluation • Surgical interventions • Interventional cardiac catheterizations (insertion of a tubular device into the heart) • Fetal echocardiograms (examination, measurement, and diagnosis of the heart using ultrasound technology) and • Approved fetal interventions
Dental Procedures	<p>Dental procedures are not covered under this Program except for injuries to sound, natural teeth, the jawbone, or surrounding tissue, or birth defects. Treatment must be initiated within one year of Injury.</p> <p>Dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not covered.</p>
Drugs	<p>In addition to the clinical guideline limitation imposed by Express Scripts (see Section 7: Prescription Drug Program), the Program excludes coverage for certain drugs, supplies, and treatments, which include, but are not limited to, the following:</p> <p>Over-the-counter medications unless specifically included</p> <p>Fluoride preparations (other than for ages 6 months to 5 years) and dental rinses</p> <p>Contraceptive foams, jellies, and ointments</p>

Exclusions	Examples
Drugs, cont.	<p>Drugs labeled “Caution: Limited by Federal Law to Investigational use or Experimental drugs”</p> <ul style="list-style-type: none"> • Experimental drugs are defined as “a therapy that has not been or is not scientifically validated with respect to safety and efficacy.” • Investigational drugs are defined as “those substances in any of the clinical stages of evaluation which have not been released by the Food and Drug Administration (FDA) for general use or cleared for sale in interstate commerce. It also includes those drugs that are in any of the clinical stages of evaluation (Phase I, II, and III) which have not been released by the FDA for general use or cleared for sale in interstate commerce.” <p>Glucose tablets Drugs used for cosmetic purposes Prescription drugs that may be properly received without charge under local, state, or federal programs, including Workers Compensation Refills of prescriptions in excess of the number specified by the physician Refills dispensed after one year from the date of order by the physician Prescription Drugs purchased for those who are ineligible for coverage under the Sandia Total Health Program Prescription Drugs taken by a donor who is not insured under the Sandia Total Health Program Medicine not Medically Necessary for the treatment of a disease or an Injury The following are excluded by the Prescription Drug Program but may be covered by UHC if Medically Necessary:</p> <ul style="list-style-type: none"> • Ostomy supplies • Implantable birth control devices such IUDs • Allergy serum • Medication that is dispensed and/or administered by a licensed facility or provider such as a hospital, home healthcare agency, or physician’s office, and the charges are included in the facility or provider bill to UHC
Equipment	<p>Exercise equipment (e.g., exercycles, weights, etc.) Hearing aids for hearing loss (see benefit under hearing aids for illness and Injury coverage) Braces prescribed to prevent injuries while you are participating in athletic activities Household items, including, but not limited to</p> <ul style="list-style-type: none"> • Air cleaners and/or humidifiers • Bathing apparatus • Scales or calorie counters • Blood pressure kits • Water beds <p>Personal items, including, but not limited to</p> <ul style="list-style-type: none"> • Support hose, except Medically Necessary surgical or compression stockings • Foam cushions • Pajamas <p>Equipment rental fees above the purchase price, with the exception of oxygen equipment</p>
Genetic Testing / Counseling	<p>Investigational, Experimental, or Unproven genetic testing is not covered. In addition, genetic counseling, including service for evaluation and explaining the implications of genetic, or inherited disease, whether provided by physicians or non physician health professionals, for the interpretation of family and medical histories to assess the risk of</p>

Exclusions	Examples
Genetic Testing / Counseling, cont.	disease occurrence or recurrence, and for assisting in making treatment decisions based upon the risk of disease occurrence or recurrence is not covered. Refer to Genetic Testing/Counseling and Preventive Care for covered services.
Hospital fees	Expenses incurred in any federal hospital, unless you are legally obligated to pay Hospital room and board charges in excess of the semi-private room rate unless Medically Necessary and approved by UHC/UBH In-hospital personal charges (e.g., telephone, barber, TV service, toothbrushes, slippers)
Hypnotherapy	Hypnotherapy is not a Covered Health Service
Infertility, Reproductive, and Family Planning	Purchase of eggs Services related to or provided to anonymous donors Services provided by a doula (labor aide) Storing and preserving sperm Donor expenses related to donating eggs/sperm (including prescription drugs); however, charges to extract the eggs from a covered employee for a donor are allowed Expenses incurred by surrogate mothers Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes Over-the-counter medications for birth control/prevention Parenting, pre-natal, or birthing classes
Investigational, Experimental, or Unproven treatment	Investigational, Experimental, or Unproven Services, unless the Sandia Total Health Program has agreed to cover them in Section 6: Covered Medical Plan Services & Limitations . Note: This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices, or pharmacological regimens are the only available treatment option for your condition. Note: This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which benefits are provided as described under clinical trials.
Miscellaneous	Eye exams except as outlined under Section 6: Covered Medical Plan Services/Limitations Eyeglasses or contact lenses prescribed, except as outlined under Section 6: Covered Medical Plan Services & Limitations . Contact lenses are not considered a prosthetic device. Modifications to vehicles and houses for wheelchair access Health club memberships and programs or spa treatments Routine foot care unless for systemic disease such as diabetes. Orthotics related to flat feet are not covered Growth Hormone – excluded unless coverage provided by prescription drug plan. Contact Express Scripts for more information. Treatment or services <ul style="list-style-type: none"> • Incurred when the patient was not covered under this Program even if the medical condition being treated began before the date your coverage under the Program ends • For Sickness or Injury resulting from your intentional acts of aggression, including armed aggression, except for injuries inflicted on an innocent bystander (e.g., you did not start the act of aggression) • For job-incurred Injury or illness for which payments are payable under any Workers Compensation Act, Occupational Disease Law, or similar law • While on active military duty

Exclusions	Examples
Miscellaneous, cont.	<ul style="list-style-type: none"> • That are reimbursable through any public program other than Medicare or through no-fault automobile insurance <p>Charges in connection with surgical procedures for sex changes</p> <p>Charges for blood or blood plasma that is replaced by or for the patient</p> <p>Conditions resulting from insurrection, except for injuries inflicted on an innocent bystander who is covered under this Program</p> <p>Christian Science practitioners and facilities</p> <p>Food of any kind unless it is the only source of nutrition, there is a diagnosis of dysphagia (difficulty swallowing), in cases of terminal cancer, or in cases of PKU or RH factor.</p> <p>Foods to control weight, treat obesity (including liquid diets), lower cholesterol, or control diabetes</p> <p>Oral vitamins and minerals (with the exception of certain prescription vitamins) as outlined in Section 7: Prescription Drug Program</p> <p>Herbs and over-the-counter medications except as specifically allowed under the Program</p> <p>Charges prohibited by federal anti-kickback or self-referral statutes</p> <p>Chelation therapy, except to treat heavy metal poisoning</p> <p>Diagnostic tests that are:</p> <ul style="list-style-type: none"> • Delivered in other than a physician’s office or healthcare facility • Self-administered home-diagnostic tests, including, but not limited to, HIV and pregnancy tests <p>Domiciliary care</p> <p>Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for ten seconds or longer). Appliances for snoring are always excluded.</p> <p>Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments when:</p> <p>Required solely for purposes of career, education, camp, employment, insurance, marriage or adoption; or as a result of incarceration</p> <ul style="list-style-type: none"> • Conducted for purposes of medical research • Related to judicial or administrative proceedings or orders or • Required to obtain or maintain a license of any type <p>Private duty nursing received on an inpatient basis</p> <p>Respite care</p> <p>Rest cures</p> <p>Storage of blood, umbilical cord, or other material for use in a Covered Health Service, except if needed for an imminent surgery</p>
Not a Covered Health Service and/or not Medically Necessary	<p>These health services, including services, supplies which are not:</p> <p>Provided for the purpose of preventing, diagnosing or treating Sickness, Injury, mental illness, Substance Abuse or their symptoms;</p> <ul style="list-style-type: none"> • Medically Necessary; • Consistent with nationally recognized scientific evidence, as available, and prevailing medical standards and clinical guidelines; • For the convenience of the covered person, physician, facility or any other person; • Included in Section 6: Covered Medical Plan Services & Limitations; • Provided to a covered person who meets the Program’s eligibility requirements; and • Not identified in general program exclusions.

Exclusions	Examples
Old claims	Claims received one year after the date charges are incurred
Physical Appearance	<p>Breast reduction/augmentation surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which the claims administrator determines is requested to treat a physiologic functional impairment or coverage required by the Women’s Health and Cancer Right’s Act of 1998.</p> <p>Any loss, expense, or charge that results from cosmetic or reconstructive surgery, except after breast cancer. Exceptions to this exclusion include:</p> <ul style="list-style-type: none"> • Repair of defects that result from surgery for which you were paid benefits under the policy • Reconstructive (not cosmetic) repair of a congenital defect that materially corrects a bodily malfunction. <p>Note: For the purposes of this exclusion, poor self-image or emotional or psychological distress does not constitute a bodily malfunction.</p> <p>Liposuction Pharmacological regimens Nutritional procedures or treatments Tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery, and other such skin abrasion procedures) Replacement of an existing intact breast implant unless there is documented evidence of silicon leakage Physical conditioning programs, such as athletic training, body building, exercise, fitness, flexibility, and diversion or general motivation Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity Wigs regardless of the reason for hair loss Treatments for hair loss</p>
Providers	<p>Services:</p> <ul style="list-style-type: none"> • Performed by a provider who is a family member by birth or marriage, including your spouse, brother, sister, parent, or child • A provider may perform on himself or herself • Performed by a provider with your same legal residence • Provided at a diagnostic facility (hospital or otherwise) without a written order from a provider • Ordered by a provider affiliated with a diagnostic facility (hospital or otherwise) when that provider is not actively involved in your medical care • Prior to ordering the service or • After the service is received <p>This exclusion does not apply to mammography testing.</p>
Services, supplies, therapy, or treatments	<p>Charges that are:</p> <ul style="list-style-type: none"> • Custodial in nature • Otherwise free of charge to you • Furnished under an alternative medical program provided by Sandia • For aromatherapy or rolfing (holistic tissue massage) • For Developmental Care after a maintenance level of care has been reached • For Maintenance Care • For massage therapy unless performed by a licensed chiropractor, physical therapist, or physician as a manual therapy technique for lymphatic drainage

Exclusions	Examples
Services, supplies, therapy, or treatments, cont.	<ul style="list-style-type: none"> • Educational therapy when not Medically Necessary • Educational testing • Smoking-cessation programs. Note: UHC offers online health coaching and health education classes via myuhc.com. • Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia, and astigmatism, including but not limited to procedures such as laser and other refractive eye surgery and radial keratotomy
Surgical and nonsurgical treatment for obesity	<p>Treatment for over-the-counter appetite control, food addictions, or eating disorders that are not documented cases of bulimia or anorexia meeting standard diagnostic criteria as determined by UHC/UBH</p> <p>The following treatments for obesity:</p> <ul style="list-style-type: none"> • Non-surgical treatment, even if for morbid obesity, and • Surgical operations for the correction of morbid obesity determined by UHC not to be Medically Necessary to preserve the life or health of the member
Transplants	<p>Health services for organ and tissue transplants except as identified under Organ Transplants in Section 6: Covered Medical Plan Services & Limitations, unless UHC determines the transplant to be appropriate according to UHC's transplant guidelines.</p> <ul style="list-style-type: none"> • Determined by UHC not to be Unproven procedures for the involved diagnoses • Not consistent with the diagnosis of the condition <p>Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available)</p> <p>Donor costs for organ or tissue transplantation to another person unless the recipient is covered under this Program</p>
Transportation	<p>Non-Emergency ambulance services are not covered</p> <p>Transportation, except ground ambulance and air ambulance services as outlined in Section 6: Covered Medical Plan Services & Limitations</p>
Travel	<p>Travel or transportation expenses, regardless of personal or business travel, even if ordered by a physician, except as identified under Travel and Lodging in Section 3: Accessing Care</p> <p>Medical repatriation outside of the United States regardless of personal or business travel</p>

Section 9. Coordination of Benefits (COB)

Coordination of Benefits (COB) is the provision that allows families with different employer group health plan coverage to receive up to 100% coverage for Covered Health Services. Under COB your health plan as the employee provides primary coverage for you and your spouse's health plan through his or her employer provides primary coverage for him or her.

Refer to the [NTESS Health Benefits Plan for Employees Summary Plan Description](#) or the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#) for more information on COB policy and rules for determining which plan provides primary coverage.

This medical Sandia Total Health Program contains a COB provision so that the benefits paid or provided by all employer group plans are not more than the total allowable expenses under this medical Sandia Total Health Program. The medical Sandia Total Health Program will not pay more than 100% of the cost of the medical treatment, nor will it pay for treatment or services not covered under this medical Sandia Total Health Program.

"Covered Health Expense" means a healthcare expense, including Deductibles, Coinsurance, and Copayments, that is covered at least in part by any of the group health plans covering the person. An expense or an expense for a Covered Health Service that is not covered by any of the group health plans is not a Covered Health Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not a Covered Health Expense. The following are additional examples of expenses or Services that are not Covered Health Expenses:

- If a covered person is confined in a private hospital room, the difference between the cost of a semi-private hospital room and the private room (unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice, or one of the group health plans routinely provides coverage for hospital private rooms) is not a Covered Health Expense.
- If a person is covered by two or more group health plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest of the usual and customary fees (or other reimbursement amount) for a specific benefit is not a Covered Health Expense.
- If a person is covered by two or more group health plans that provide benefits or Services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not a Covered Health Expense.
- If a person is covered by one group health plan that calculates its benefits or Services on the basis of usual and customary fees and another group health plan that provides its benefits or Services on the basis of negotiated fees, the primary plan's payment arrangements shall be the Covered Health Expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or Service for a

payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Covered Health Expense used by the secondary plan to determine its benefits.

- The amount a benefit is reduced by the primary plan because a covered person does not comply with the plan provisions is not a Covered Health Expense. Examples of these provisions are second surgical opinions, precertification of admissions, etc.

Refer to the [NTESS Health Benefits Plan for Employees Summary Plan Description](#) or the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#) for more information on “Special Rules for Covered Medicare-Primary Members” and “Provision for Covered Members with End-Stage Renal Disease (ESRD).”

Beginning January 1 of every year or if you are a new enrollee, you are required to provide an update to UHC on whether any of your covered family members have other insurance. This notification is also required if your family member enrolls in another medical plan during the year. If you do not provide this information to UHC, your covered family members' claims may be denied. You may update your other insurance information by calling UHC at 877-498-7652.

Refer to [Section 7: Prescription Drug Program](#) for information on eligibility to use the Prescription Drug Program, as well as how COB works, if your covered family member has other insurance coverage.

Section 10. How to File a Claim

This section provides an overview of how to file a claim and the receipt of benefit payments under the Sandia Total Health Program.

Filing an Initial Claim

Refer to the Claims and Appeals Section of the [NTESS Health Benefits Plan for Employees Summary Plan Description](#) or the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#) for claim definitions, timeframes for disposition of Urgent Care, pre-service, concurrent care, and post-service claims, and the information that you are entitled to receive from the claims administrator upon processing of your claim.

IMPORTANT: All claims must be submitted within one year from the date of service to be eligible for consideration of payment. This one-year requirement will not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends. It is recommended that claims be submitted as soon as possible after the medical or prescription expenses are incurred. HRA funds will be rolled-over to the subsequent calendar year after 90 days from the end of the plan year; therefore, if you file a claim, for example, in May of 2012 for 2011 services, HRA funds will not be available to pay that claim. If you need assistance in filing a claim, call UHC Customer Service at 877-835-9855 or Express Scripts at 877-817-1440.

In-Network Claims Processing

Generally, when you seek services through an in-network provider, the provider verifies eligibility and submits the claims directly to the claims administrator for processing. There are generally no claim forms necessary to obtain in-network benefits. Refer to [Section 5: Health Reimbursement Account](#) for information on payments from your HRA, and [Section 7: Prescription Drug Program](#), for information on how to use network retail and mail order pharmacy benefits.

Out-of-Network Claims Processing

When you seek services through an out-of-network provider, you will need to submit the claim for reimbursement. The provider may not verify eligibility. It is your responsibility to verify you are eligible for benefits by either calling the claims administrator or going to www.myuhc.com or www.express-scripts.com. You can obtain claim forms from the claims administrator.

Submit the claim form to the claims administrator immediately after the expense is incurred but no later than one year from the date of service. Refer to the “Important” note above. Completion and submission of the claim form does not guarantee eligibility of benefits.

If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, age and relationship to the [Employee][Participant].
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s);
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
 - The Current Procedural Terminology (CPT) codes.
 - A description of, and the charge for, each service.
 - The date the Sickness or Injury began.
 - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UHC, at the address on your ID card.

After UHC has processed your claim, your non-Network provider will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider any difference between what you were billed and what the Plan paid.

Process for Out-of-Network Claims Processing for Medical Care

To obtain reimbursement for medical care, attach the itemized medical bill to the claim form and mail it to the address shown on the claim form or the address on your Sandia Total Health Program ID card. Itemized medical bills should include:

- Patient's full name
- Date and place of treatment or purchase
- Diagnosis
- Type of service provided
- Amount charged

- Name and address of provider and tax identification number, if available
- If other insurance is primary, the EOB (from the primary insurer) attached to your claim form

Process for Out-of-Network Claims Processing for Prescription Drugs

If you have a prescription filled by an out-of-network pharmacy, complete a Direct Member Reimbursement Form, attach pharmacy receipts, and send your claim to Express Scripts.

Benefits Payments

Refer to the [NTESS Health Benefits Plan for Employees Summary Plan Description](#) or [NTESS Health Benefits Plan for Retirees Summary Plan Description](#) for general information on benefits payments.

UHC will pay benefits to you unless:

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

Express Scripts will pay benefits to the provider when you use a network or mail order pharmacy. If you use an out-of-network provider, Express Scripts will pay any applicable benefits to you.

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

Each month in which UHC processes at least one claim for you or a covered dependent, you will receive a health statement in the mail. A health statement is a summary of your recent claims, plus remaining balances for your HRA, Deductibles, and Out-of-Pocket Limits in one easy-to-read format. It provides a clearer picture of your healthcare spending, plus includes meaningful tips to help you use your benefits. A health statement will be mailed within 30 days if you received care and you need to pay for a part of the service. However, if you received care and the program pays in full, you will receive a Health Statement in the mail within 90 days that shows the service you received and the amount that was paid. And, if for any reason, you'd like to view your claims activity more frequently, you can log on to myuhc.com at any time of day or night.

If any claims are denied in whole or in part, you will still receive an Explanation of Benefits (EOB) which will include the reason for the denial or partial payment. The EOB will let you know if there is any portion of the bill you need to pay. If you would rather track claims online, you may elect to discontinue receipt of paper health statements or EOBs at www.myuhc.com. You may also elect to continue to receive EOBs by making the appropriate elections online or by calling UHC Customer Service at 877-835-9855.

For eligible prescription drug claims processed through a Direct Member Reimbursement Form, you will receive an EOB with the payment from Express Scripts.

Recovery of Excess Payment

The Claims Administrator has the right at any time to recover any amount paid by the Sandia Total Health Program for covered charges in excess of the amount that should have been paid under the provisions. Payments may be recovered from you, providers of service, and other medical care plans.

IMPORTANT: By accepting benefits under the Sandia Total Health Program, you agree to reimburse payments made in error and cooperate in the recovery of excess payments.

Section 11. How to File an Appeal

This section outlines how to file an appeal with either UnitedHealthcare or Express Scripts. The respective claims administrator will notify you of the decision regarding any appeal within the applicable time frames. Refer to the Claims and Appeals of the [NTESS Health Benefits Plan for Employees Summary Plan Description](#) or the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#) for information on general appeal time frames under ERISA, as well as your right to information that you are entitled to receive from the claims administrator upon the denial of an appeal.

Filing an Appeal

IMPORTANT: Upon denial of a claim, you have 180 calendar days of receipt of the notification of Adverse Benefit Determination to appeal the claim. You must exhaust the appeals process before you can seek other legal recourse. If after exhausting the appeals process, you are still not satisfied, your remaining remedies include the right to bring suit in Federal Court under Section 502(a) of ERISA and voluntary dispute resolution options, such as mediation or independent external review.”

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.

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 you and the doctor to decide what, if any, care you receive.

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 Eligibility Appeals Procedure in the NTESS Health Benefits Plan for Employees Summary Plan Description or NTESS Health Benefits Plan for Retirees Summary Plan Description
Eligibility based on incapacitation determinations	Contact the claims administrator for assistance
Benefit Determinations	Refer to the procedures noted below

Before requesting a formal appeal, you may informally contact customer service. If the customer service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing at the address noted below. However, if you are not satisfied with a claim determination, you may appeal it as described below, without first informally contacting customer service.

If you are appealing an Urgent Care claim denial, please refer to Urgent Claims Appeals under UHC or Expedited Appeal under Express Scripts.

If you disagree with a pre-service or post-service claim determination, you can contact the Claims Administrator in writing to formally request an appeal. Written communication should include:

- Patient's name and ID number as shown on the ID card
- Provider's name
- Date of medical service
- Reason you disagree with the denial
- Any documentation or other written information to support your request

You, or your doctor, can send the written appeal to:

Medical/Behavioral Health:

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

Prescription Drugs:

Express Scripts, Inc.
Attn: Pharmacy Appeals
Mail Route BL 0390
6625 West 78th Street
Bloomington, MN 55439
Fax: 877-852-4070

Prescription Administration Appeals:

Express Scripts, Inc.
Attn: Administrative Appeals Department
PO BOX 66587
St. Louis, MO 63166-6587
Phone: 800-946-3979

Prescription Clinical Appeals:

Express Scripts, Inc.
Attn: Clinical Appeals Department
PO BOX 66588
St. Louis, MO 63166-6588
Phone: 800-753-2851

UnitedHealthcare Appeals Process

A qualified individual who was not previously involved in the claim decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a healthcare professional with appropriate expertise in the field who was not previously involved in the prior determination. UnitedHealthcare may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon written request and free of charge you may examine documents relevant to your claim and/or appeals and submit opinions and comments. UHC will review all claims in accordance with the rules established by the U.S. Department of Labor. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, UHC will provide it to you free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. UHC's decision will be final.

Pre-Service and Post-Service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service claims (as defined in [Section 10: How to File a Claim](#)), the first level will be conducted and you will be notified by UnitedHealthcare of the decision within 15 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to UHC in writing within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted, and you will be notified by UHC of the decision within 15 days from receipt of the request for review of the first level appeal decision.
- For appeals of post-service claims (as defined in [Section 10: How to File a Claim](#)), the first level appeal will be conducted and you will be notified by UHC of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to UHC in writing within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted, and you will be notified by UHC of the decision within 30 days from receipt of the request for review of the first level appeal decision.

Urgent Claims Appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. The appeal does not need to be submitted in writing. You or your physician should call UHC at 877-835-9855 as soon as possible. UHC will provide you with a written or electronic determination as soon as possible, taking into account medical exigencies. The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	Timing
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	24 hours
You must then provide completed request for Benefits to UnitedHealthcare within:	48 hours after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	72 hours
If UnitedHealthcare denies your request for Benefits, you must appeal the adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	72 hours after receiving the appeal
*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care request for Benefits.	

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or

- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- a preliminary review by UnitedHealthcare of the request;
- a referral of the request by UnitedHealthcare to the IRO; and
- a decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the Plan at the time the healthcare service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare

will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- all relevant medical records;
- all other documents relied upon by UnitedHealthcare; and
- all other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the healthcare service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the

individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or

- a final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or healthcare service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- is or was covered under the Plan at the time the healthcare service or procedure that is at issue in the request was provided.
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Express Scripts Appeals Process

Two levels of appeal are permitted for each type of claim that is denied (called an Adverse Determination). Appeal determinations will be rendered as specified in the Claims and Appeals Procedures, of the [NTESS Health Benefits Plan for Employees Summary Plan Description](#) or the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#).

Pre-Service and Post-Service Claim:

- A. An appeal may be filed by you, your representative, or by a prescriber (on your behalf).
- B. You, your representative or prescriber, on your behalf, may submit written comments, documents, records and other information relevant to your request for an appeal. All such information is taken into account during the appeal process without regard to whether such information was submitted or considered when making the initial Adverse Determination.
- C. Upon initial receipt of an appeal, a clinical pharmacist will review the appeal (First-Level) and may overturn the initial Adverse Determination, if appropriate. If the initial Adverse Determination is overturned, you and the prescriber, if the prescriber filed the appeal on your behalf, will be notified of the determination in writing.
- D. If the clinical pharmacist does not overturn the Adverse Determination, Express Scripts will forward the appeal request to a physician (Second-Level) in the same profession and in a similar specialty that typically manages the medical condition, procedure, or treatment as mutually deemed appropriate. The physician reviewer will make the appeal determination. The clinical pharmacist completing the review of the appeal and the reviewing physician must hold an active, unrestricted license and board certification, if applicable, by the American Board of Medical Specialties (doctors of medicine) or the Advisory Board of Osteopathic Specialists (doctors of osteopathic medicine).
- E. If you are not satisfied with the decision following completion of the second-level appeal process, you may request that Express Scripts forward your appeal request to an independent review organization (IRO). You must submit this request within 120 calendar days of your receipt of the Second-Level appeal review denial. The IRO will engage a physician in the same profession and in a similar specialty that typically manages the medical condition, procedure, or treatment as mutually deemed appropriate. The physician reviewer will make the appeal determination.
- F. As with any Adverse Determination, approved clinical criteria will be employed to evaluate the claim under review during an appeal.
- G. If within 5 working days after the filing date of the appeal there is not sufficient information to process the appeal, you, your representative or the prescriber, who filed the appeal on your behalf, will be notified by written communication of the information required to process the appeal and directions on how to resubmit the appeal.
- H. If any of the appeal reviews overturns the Adverse Determination, the benefit will be allowed.

Urgent Claims (Expedited) Appeal:

- A. An expedited appeal may be filed by you, your representative or a prescriber, acting on your behalf. Contact Express Scripts customer service at 877-817-1440 to initiate an appeal.

- B. The clinical pharmacist or physician reviewer, in discussion with you and/or independent third-party review organization, will determine whether the appeal constitutes an expedited appeal.
- C. Upon initially receiving an expedited appeal, a clinical pharmacist will review the expedited appeal and may overturn the initial Adverse Determination, if appropriate. If the initial Adverse Determination is overturned, you and the prescriber, on your behalf, will be notified of the outcome in writing.
- D. If the clinical pharmacist upholds the Adverse Determination, Express Scripts will forward the appeal request to an external Independent Review Organization (IRO). The IRO will engage a physician in the same profession and in a similar specialty that typically manages the medical condition, procedure, or treatment as mutually deemed appropriate. The physician reviewer will make the Appeal determination. The clinical pharmacist completing the review of the appeal and the reviewing physician will each hold an active, unrestricted license and board certification, if applicable, by the American Board of Medical Specialties (doctors of medicine) or the Advisory Board of Osteopathic Specialists (doctors of osteopathic medicine).
- E. If within 24 hours after the filing date of the expedited appeal, there is not sufficient information to process the appeal, you, your representative or the prescriber, who filed the appeal on your behalf, will be notified verbally with a follow up in writing of the information required to process the appeal and directions on how to resubmit the appeal.
- F. The decision on an expedited appeal will be rendered and communicated verbally within 24 hours of receipt of the appeal request.

Section 12. Sandia Total Health Administrative Services

Claims Administrators

The Claims Administrators are the third parties designated by Sandia to receive, process, and pay claims according to the provisions of the Sandia Total Health Program. For medical, behavioral health, and EAP claims, this is UHC, and for Outpatient prescription drugs this is Express Scripts.

UHC Member Identification Cards

IMPORTANT: Always present your Sandia Total Health Program member identification card when obtaining healthcare.

If you have elected single coverage, you will receive one Sandia Total Health Program ID card. If you have elected any other coverage, you will receive two Sandia Total Health Program ID cards. You may obtain additional ID cards through myuhc.com or by calling UHC Customer Service at 877-835-9855. The Sandia Total Health Program ID Card identifies you to providers as an eligible member. This card contains:

- Your name and the names of any covered dependents
- A unique subscriber ID number that has been assigned to you by UHC and is linked to the primary subscriber's Social Security number in the UHC system
- The group number
- The claims filing address
- Customer Service phone number

Express Scripts Member Identification Cards

If you are a new enrollee in the Sandia Total Health Program, you will receive new Express Scripts ID cards. If you need additional identification cards, you may call Express Scripts Customer Service at 877-817-1440 and request them.

IMPORTANT: Always present your Express Scripts member ID card when obtaining prescriptions at a retail pharmacy. If you do not use your card, you are not eligible to receive reimbursement for the prescription.

My UHC Website

The UHC member website, www.myuhc.com, provides information at your fingertips anywhere and anytime you have access to the Internet. Myuhc.com offers practical and

personalized tools and information so you can get the most out of your benefits. Once you have registered at www.myuhc.com, you can:

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

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

Express Scripts Website

The Express Scripts member website, www.express-scripts.com, provides information at your fingertips anywhere and anytime you have access to the Internet. Express Scripts.com offers practical and personalized tools and information so you can get the most out of your benefits. Log on to:

- Locate retail network pharmacies
- Price prescription drugs at retail network pharmacies and mail service
- Refill prescriptions through mail service
- Find out what drugs are covered under the Program

You can also access the above information on the Express Scripts Rx phone app from any smartphone. Simply enter “Express-scripts.com” into your smartphone browser or download the app by going to the Apple App Store, Google Play Store, or Blackberry World.

Contact Telephone Numbers and Hours of Operation

Function	Telephone Numbers
UnitedHealthcare – www.myuhc.com	
Customer Service <ul style="list-style-type: none"> • Claims questions • Check eligibility • Benefit information • Participating providers • Case management 	877-835-9855 6:00 a.m. - 8:00 p.m. MT Monday - Friday
Prior Authorization to Personal Health Support SM	877-835-9855 6:00 a.m. - 8:00 p.m. MT, Monday - Friday
Precertification for certain behavioral health services	877-835-9855 6:00 a.m. - 8:00 p.m. MT, Monday - Friday
Precertification for Employee Assistance Program (EAP)	866-828-6049 24 hours a day, 7 days a week
Advocate4Me NurseLine	800-563-0416 24 hours a day, 7 days a week
Virtual Visits for diagnoses & treatment of low acuity conditions	www.myuhc.com or HealthforMe mobile app 24 hours a day, 7 days a week
Onsite Advocate (Bldg. 832)	505-844-0657 Walk-ins / appointments: 8:00 – 11:30 a.m. and 12:30 to 4:30 p.m. MT Monday - Thursday Messages recorded after hours, on weekends, and on holidays
Healthy Pregnancy Program	888-246-7389 8:00 a.m. - 10:00 p.m. MT, Monday - Friday
Centers of Excellence (COE) Programs <ul style="list-style-type: none"> • Transplant Resource Services Program • Cancer Resources Services Program • Congenital Heart Disease Resource Services Program 	877-835-9855
UnitedHealthcare Allies Health Discount Program	800-860-8773 www.unitedhealthallies.com
Express Scripts Prescription Drug Program– www.express-scripts.com	
Customer Service <ul style="list-style-type: none"> • Refill a mail order prescription • Determine if a pharmacy is in the pharmacy network • Obtain information about your benefits • Speak with a pharmacist about a prescription • Request additional ID cards 	877-817-1440 24 hours a day seven days a week
Sandia National Laboratories – hr.sandia.gov	
HR Customer Service, Bldg. 832 Enrollment/disenrollment in benefit programs, forms, e.g., claims, others	505-844-4237 , option 2 Fax: 505-844-7535 8:00 a.m. - 4:30 p.m. MT

When You Change Your Address

When you move, you must change your address in the Sandia database. Active employees can change their address through Sandia's HR Self-Service. Retirees must change their address with ViaBenefits (formerly OneExchange) and Sandia National Laboratories.

If you move to California and wish to enroll in Sandia Total Health administered by Kaiser Permanente for Active employees, you must enroll through Sandia Benefits within 31 calendar days of the move. If you are a retiree, refer to the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#) for more details.

Section 13. Definitions

Please note that certain capitalized words in this Program Summary 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.

Adverse Benefit Determination or Adverse Determination	<p>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:</p> <ul style="list-style-type: none"> • An individual being ineligible to participate in the Sandia Total Health; • Utilization review; • A service being characterized as Investigational, Experimental, or Unproven or not medically necessary or appropriate; • A concurrent care decision; and • For medical claims, certain retroactive terminations of coverage, whether or not there is an adverse effect on any particular benefit at that time.
Coinsurance	The percentage of a covered health service which the plan pays after you've met the Deductible.
Congenital Anomaly	A physical developmental defect that is present at birth.
Cost-effective	Least expensive equipment that performs the necessary function. Applies to Durable Medical Equipment and prosthetic appliances/devices.
Cosmetic Procedures	Procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is an example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function, such as in breathing.
Covered Member	An enrolled participant or enrolled dependent. This term refers to a person only while enrolled under the Sandia Total Health Program. References to "you" and "your" throughout this document are references to a Covered Member.
Covered Health Services	<p>Covered Health Services are those health services and supplies that are:</p> <ul style="list-style-type: none"> • Provided for preventing, diagnosing, or treating Sickness, Injury, mental illness, Substance Abuse, or their symptoms • Included in this section (subject to limitations and conditions and exclusions as stated in this Benefit Program Summary) • Provided to you, if you meet the eligibility • requirements as described in the NTESS Health Benefits Plan for Employees Summary Plan Description or NTESS Health Benefits Plan for Retirees Summary Plan Description • Medically Necessary
Custodial Care	<p>Services or supplies, regardless of where or by whom they are provided, that</p> <ul style="list-style-type: none"> • A person without medical skills or background could provide or could be trained to provide or • Are provided mainly to help you with daily living activities, including (but not limited to): <ol style="list-style-type: none"> 1. Walking, getting in and/or out of bed, exercising and moving

Custodial Care, cont.	<p>2. Bathing, toileting, administering enemas, dressing, and assisting with any other physical or oral hygiene needs</p> <p>3. Assistance with eating by utensil, tube, or gastrostomy</p> <p>4. Homemaking, such as preparation of meals or special diets, and house cleaning</p> <p>5. Acting as a companion or sitter</p> <p>6. Supervising the administration of medications that can usually be self-administered, including reminders of when to take such medications</p> <ul style="list-style-type: none"> • Provide a protective environment • Are part of a maintenance treatment plan or are not part of an active treatment plan intended to or reasonably expected to improve your Sickness, Injury, or functional ability, or • Are provided for the convenience of you or the caregiver or are provided because your own home arrangements are not appropriate or adequate.
Deductible	Covered charges incurred during a calendar year that you must pay in full before the Sandia Total Health Program pays benefits. Does not apply to Outpatient prescription drugs purchased through Express Scripts.
Developmental Care	<p>Services or supplies, regardless of where or by whom they are provided, that:</p> <ul style="list-style-type: none"> • Are provided to you if you have not previously reached the level of development expected for your age in the following areas of major life activity: <ul style="list-style-type: none"> ▪ Intellectual ▪ Physical ▪ Receptive and expressive language ▪ Learning ▪ Mobility ▪ Self-direction ▪ Capacity for independent living ▪ Economic self-sufficiency • Are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to Injury or Sickness) or are educational in nature
Eligible Expenses	<p>Eligible Expenses – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UHC as stated below:</p> <p>Eligible Expenses are determined solely in accordance with UHC's reimbursement policy guidelines. UHC develops the reimbursement policy guidelines, in UHC's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:</p> <ul style="list-style-type: none"> • As indicated in the most recent edition of the <i>Current Procedural Terminology (CPT)</i>, a publication of the <i>American Medical Association</i>, and/or the <i>Centers for Medicare and Medicaid Services (CMS)</i>. • As reported by generally recognized professionals or publications. • As used for Medicare. • As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.
Emergency	See Medical Emergency

Experimental or Investigational	<p>Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other healthcare services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time UHC makes a determination regarding coverage in a particular case, are determined to be any of the following:</p> <ul style="list-style-type: none"> • Not approved by the <i>U.S. Food and Drug Administration (FDA)</i> to be lawfully marketed for the proposed use and not identified in the <i>American Hospital Formulary Service</i> or the <i>United States Pharmacopoeia Dispensing Information</i> as appropriate for the proposed use. • Subject to review and approval by any institutional review board for the proposed use (Devices which are <i>FDA</i> approved under the <i>Humanitarian Use Device</i> exemption are not considered to be Experimental or Investigational.) <p>Exceptions:</p> <ul style="list-style-type: none"> • Clinical Trials for which Benefits are available as described under <i>Clinical Trials</i>. • If you are not a participant in a qualifying Clinical Trial and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the UHC may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, UHC must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition. <p>Refer to Section 7: Prescription Drug Program, for Experimental or Investigational language for Express Scripts</p>
Genetic Testing	Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.
Health Assessment	A Health Assessment is a confidential online questionnaire that asks you about your health history, lifestyle behaviors (such as smoking and exercise habits) and your willingness to make changes.
Hospice	A program provided by a licensed facility or agency that provides home healthcare, homemaker services, emotional support services, and other service provided to a terminally ill person whose life expectancy is six months or less as certified by the person's physician
Injury	Bodily damage from trauma other than Sickness, including all related conditions and recurrent symptoms
Inpatient Stay	An uninterrupted confinement of at least 24 hours following formal admission to a hospital, Skilled Nursing Facility or inpatient rehabilitation facility
Intensive Outpatient Program	Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.
Maintenance Care	Treatment beyond the point where material or significant improvement is to be expected. The treatment results in no measurable or objective improvement. For modality treatments, such as Nonsurgical Spinal Treatment or physical therapy, the treatment provides no evidence of lasting benefit; treatment provides only relief of symptoms.
Medical Emergency	A sudden and unforeseeable Sickness or Injury that arises suddenly, and in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health

Medically Necessary	<p>Medically Necessary – healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by UHC or its designee, within UHC’s sole discretion.</p> <ul style="list-style-type: none"> • In accordance with <i>Generally Accepted Standards of Medical Practice</i>. • Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders disease or its symptoms. • Not mainly for your convenience or that of your doctor or other healthcare provider. • Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms. <p><i>Generally Accepted Standards of Medical Practice</i> are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.</p> <p>If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. UHC reserves the right to consult expert opinion in determining whether healthcare services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within UHC’s sole discretion.</p> <p>UHC develops and maintains clinical policies that describe the <i>Generally Accepted Standards of Medical Practice</i> scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by UHC and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling the number on your ID card, and to Physicians and other healthcare professionals on www.unitedhealthcareonline.com.</p>
Nonsurgical Spinal Treatment	<p>Detection or nonsurgical correction (by manual or mechanical means) of a condition of the vertebral column, including</p> <ul style="list-style-type: none"> • Distortion • Misalignment • Subluxation <p>to relieve the effects of nerve interference that results from or relates to such conditions of the vertebral column.</p>
Out-of-Pocket Limit	<p>Your financial responsibility for covered medical expenses before the Program reimburses additional covered charges at 100%, with no Deductible, for the remaining portion of that calendar year.</p>
Outpatient	<p>A person who visits a clinic, Emergency room, or health facility and receives healthcare without being admitted as an overnight patient (under 24-hour stay).</p>
Outpatient Surgery	<p>Any invasive procedure performed in a hospital or surgical center setting when a patient is confined for a stay of less than 24 consecutive hours.</p>

Partial (or day) Hospitalization	A program that provides covered services to persons who are receiving professionally directed evaluation or treatment and who spend only part of a 24-hour period (but at least four hours per day) or 20 hours per week in a hospital or treatment center.
Primary Covered Member	The person for whom the coverage is issued; that is, the Sandia employee, retiree, surviving spouse, Long Term Disability Terminee or the individual who is purchasing temporary continued coverage.
Prior Authorization	The process whereby you call UHC/UBH to obtain prior approval for certain services.
Residential Treatment Facility	A Residential Treatment Facility provides acute overnight services for the care of a Substance Abuse disorder or overnight mental health services for those who do not require acute care.
Sickness	Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness, or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness, or substance-related and addictive disorder.
Skilled Nursing Facility	A nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a hospital is considered a Skilled Nursing Facility for purposes of the Sandia Total Health Program.
Sound Natural Teeth	Teeth that: <ul style="list-style-type: none"> • Are whole or properly restored • Are without impairment or periodontal disease • Are not in need of the treatment provided for reasons other than dental injury
Specialist	Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, family practice or general medicine.
Substance Use Disorder Services	Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> , unless those services are specifically excluded. The fact that a disorder is listed in the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> does not mean that treatment of the disorder is a Covered Health Service.
Unproven Services	Health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature. Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received. Well-conducted cohort studies are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group. UHC has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UHC issues medical and drug policies that describe the clinical evidence available with respect to specific healthcare services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com . Note: If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UHC may, at their discretion,

Unproven Services cont.	<p>consider an otherwise Unproven service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UHC must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.</p> <p>UHC may, in their discretion, consider an otherwise Unproven service to be a Covered Health Service for a covered person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:</p> <ul style="list-style-type: none"> • If the service is one that requires review by the U.S. Food and Drug Administration (FDA), it must be FDA-approved • It must be performed by a physician and in a facility with demonstrated experience and expertise • You must consent to the procedure acknowledging that UHC does not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective • At least two studies must be available in published peer-reviewed medical literature that would allow UHC to conclude that the service is promising but unproven • The service must be available from a network physician and/or network facility • The decision about whether such a service can be deemed a Covered Health Service is solely at UHC's discretion. Other apparently similar promising but Unproven Services may not qualify
Urgent Care	Treatment of an unexpected Sickness or Injury that is not life threatening but requires Outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering such as high fever, a skin rash, or an ear infection.
Urgent Care Facility	Can be attached to a hospital or be freestanding, staffed by licensed physicians and nurses, and providing healthcare services.

Section 14. UnitedHealth Allies Health Discount Program

The UnitedHealth Allies Health Discount Program helps you and your covered dependents save up to 50% on certain healthcare services that may not be covered under the Sandia Total Health Program.

Products and services available under the UnitedHealth Allies Health Discount Program include:

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

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

To locate participating healthcare professionals:

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

Note: The UnitedHealth Allies Health Discount Program is made available solely by UHC to those in the Sandia Total Health Program and is not part of the Sandia Total Health Program itself. Sandia does not sponsor or maintain this program, but has agreed to make you aware of the services. Sandia is not responsible for the design or administration of this program. Contact UHC at 877-835-9855 with any questions or concerns about the program. The provisions of your ERISA Rights do not apply to this program. Sandia is including this program description here for your convenience.