Sandia National Laboratories

CIGNA Premier PPO Plan

Summary Plan Description

Effective: January 1, 2006

CIGNA Premier PPO Plan

This Summary Plan Description summarizes the CIGNA Premier Preferred Provider Organization (PPO) Plan operations, benefits, claim filing procedures, and other Plan provisions. As you read through this Summary Plan Description, you'll learn about the covered services and special programs and tools that this Plan offers to help you take better care of yourself.

The CIGNA Premier PPO Plan is being offered by Sandia National Laboratories to its employees, non-***Medicare primary*** retirees, and other eligible non-***Medicare primary*** individuals. This Plan allows you to see any doctor you prefer, in or outside of the Open Access Plus network, for your medical needs.

In addition to medical services, this Plan includes an ***Employee Assistance Program***, a Behavioral Health Program, a Disease Management Program, and a Prescription Drug Program.

As alternatives to this Plan, Sandia offers to its:

- employees and eligible dependents the UnitedHealthcare Premier PPO, UnitedHealthcare Standard PPO, CIGNA In-Network Plan, and Kaiser HMO (CA)
- non-***Medicare*** retirees and other non-***Medicare eligible*** individuals the UnitedHealthcare Premier PPO, UnitedHealthcare High Deductible Health Plan, CIGNA In-Network Plan, and Kaiser HMO (CA)
- ***Medicare primary*** retirees and other ***Medicare primary*** individuals the UnitedHealthcare Senior Premier PPO, CIGNA Senior Premier PPO, Presbyterian ***Medicare*** PPO (NM), Lovelace Senior Plan (NM), and Kaiser Senior Advantage Plan (CA)

These alternatives are described by their individual Summary Plan Descriptions.

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

The CIGNA Premier PPO Plan is a self-insured plan for eligible members of Sandia Corporation, 1515 Eubank SE, Albuquerque, NM 87123 (employer identification number 85-0097942, plan number 519). This Plan is administered on a calendar year basis from January 1 through December 31 for accumulation of maximums, ***deductibles***, claim filing, and filing of reports to the Department of Labor. CIGNA HealthCare, the ***claims administrator*** has assigned Sandia group plan number **3172368**. For information con-

cerning service of legal process, contact the Sandia Legal Division, Sandia National Laboratories, 1515 Eubank SE, Albuquerque, NM 87123.

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

Copies of the Summary Plan Description and the administrative manual are available (for a fee) from your Sandia Corporation (Sandia) Benefits office.

The CIGNA Premier PPO Plan is maintained at the discretion of Sandia and is not intended to create a contract of employment and does not change the at-will employment relationship between you and Sandia. The Sandia Board of Directors (or designated representative) reserves the right to change or amend any or all provisions of this *Plan*, and to terminate the *Plan* at any time without prior notice, subject to applicable collective bargaining agreements. Should the CIGNA Premier PPO Plan be terminated or changed, it will not affect your right to benefits to which you have already become entitled.

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Section 1. Summary of Plan Changes

The CIGNA Premier PPO Plan is being offered in conjunction with the UnitedHealthcare Premier PPO Plan that replaced the Sandia Top PPO Plan that was administered by United of Omaha.

The CIGNA Premier PPO and the UnitedHealthcare Premier PPO plans offer the same general benefits except that the Prescription Drug Program under the UnitedHealthcare Premier PPO Plan is a carve-out plan administered by PharmaCare. Other differences between the UnitedHealthcare Premier PPO Plan and the CIGNA Premier PPO Plan include:

- Network of ***providers*** and facilities
- Disease management programs
- Case management ***providers***
- Website tools and services
- Nurse advice line
- Member services 1-800 number
- Account management team

Review the UnitedHealthcare Premier PPO Plan, Summary Plan Description, Section 1. Summary of Plan Changes from the Top PPO Plan, for specific plan changes.

The specific changes between the Sandia Top PPO Plan and the UnitedHealthcare Premier PPO Plan that apply to the CIGNA Premier PPO Plan are:

- ***Coinsurance*** replaced ***copays*** (in-network) for health services, with the exception of office visits (in-network).
  - ***Coinsurance*** is at 15 percent of ***eligible expenses*** for in-network medical and ***behavioral health*** services (after the ***deductible***, if applicable) and 30 percent of ***eligible expenses*** for out-of-network medical service (after the ***deductible***). Out-of-network ***behavioral health*** remains at 50 percent of ***eligible expense***, after the ***deductible***.
  - Office visits remain at a ***copay,*** with the exception of laboratory, radiation therapy, radiology, chemotherapy, supplies, and medical tests, which are at the 15 percent of ***eligible expenses*** (after the ***deductible***) for in-network services.
  - The $25 out-of-network office visit ***copay*** has been dropped.
- Certain in-network preventive care is covered at 100 percent of ***eligible expenses***.
- The out-of-network ***deductible*** for employees and their covered dependents increased from $300 to $500 for an individual and from $900 to $1500 for a family of three or more.

- Retirees, survivors, ***long-term disability terminees*** and their covered dependents now have an in-network ***deductible*** of $250 for an individual and $750 for a family of three or more.
- The out-of-network ***deductible*** for retirees, survivors, ***long-term disability terminees*** and their covered dependents increased from $300 to $750 for an individual and from $900 to $2,250 for a family of three or more.
- The ***out-of-pocket maximum*** for employees and their covered dependents increased as follows:
  - In-Network – $1,000 to $1,500 for an individual, and $2,000 to $3,000 for a family of two or more
  - Out-of-Network – $1,500 to $3,000 for an individual, and $4,000 to $6,000 for a family of two or more
- The ***out-of-pocket maximum*** for retirees, survivors, ***long-term disability terminees*** and their covered dependents increased as follows:
  - In-Network – $1,000 to $1,750 for an individual, and $2,000 to $3,500 for a family of two or more
  - Out-of-Network – $1,500 to $3,500 for an individual, and $4,000 to $7,000 for a family of two or more
- Prescription drug ***copays*** increased at retail network pharmacies as follows:
  - Generic: $9 maximum to $12 maximum
  - Preferred Brand Name: $17 minimum to $25 minimum, and $32 maximum to $40 maximum
  - Non-Preferred Brand Name: $30 minimum to $40 minimum and $50 maximum to $60 maximum
- Prescription drug ***copays*** increased at mail order as follows:
  - Generic: $13 to $18
  - Preferred Brand Name: $43 to $65
  - Non-Preferred Brand Name: $75 to $100
- The provision allowing late enrollment (beyond the 31-calendar-day period) for new hires and dependents and for new dependents of currently covered primary members has been dropped.
- Although ***primary covered members*** can still enroll a new dependent based on a birth or marriage within 31 calendar days, members must provide a copy of the birth or marriage certificate within 60 calendar days of the birth or marriage or the dependent will be disenrolled from the Plan.
- ***Primary covered members*** who have dependents covered under the Plan who are not tax dependents as identified under ***IRC*** Section 152 for purposes of health care coverage may have imputed income on the applicable premium.
- Premium-sharing increased for most ***primary covered members***.

- Coverage tiers for premium-sharing changed from: employee only, employee plus one dependent, and employee plus two or more dependents to employee only, employee and spouse, employee and ***child(ren)***, and employee, spouse, and ***child(ren)***.
- Prior notification and ***pre-certification*** requirements have changed.
- A Disease Management Program has been added. This is a voluntary program to help members manage chronic conditions for asthma, diabetes, heart disease, low-back pain, and chronic obstructive pulmonary disease.

Highlights of the CIGNA Premier PPO Plan

The CIGNA Premier PPO Plan is administered by CIGNA HealthCare. This Plan provides CIGNA HealthCare's Open Access Plus network, which means that members are free to see either an in-network (CIGNA contracted) or out-of-network (non-CIGNA contracted) ***provider*** or facility.

- This Plan gives members referral-free access to CIGNA HealthCare's nationwide network of ***providers,*** which means that the member does not need a referral from a ***primary care physician*** to see a ***specialist.***
- Both in- and out-of-network coverage is available, although members receive a greater benefit when they choose an in-network ***provider***.
- Coverage is available worldwide for ***emergency*** and ***urgent care***. ***Follow-up care*** while on travel is covered at the in-network level of benefit if you are outside the United States or not within 30 miles of an in-network ***provider*** inside the United States.
- ***Copayments*** that you pay to see a ***physician*** do not apply to your annual, calendar year, ***out-of-pocket maximum***.
- ***Coinsurance*** (indicated as a percentage) is the amount the patient pays, after meeting the ***deductible***, and is based on either the ***negotiated fees*** (in-network) or ***usual and customary*** (***U&C***) charges (out-of-network). ***Coinsurance*** amounts apply to the ***deductible***, if applicable, and to the ***out-of-pocket maximum***.
- Prescription drug ***copays*** and out-of-network ***behavioral health*** benefits do not apply to the ***out-of-pocket maximum***.
- The Prescription Drug Program, administered through CIGNA HealthCare, is a three-tiered plan that includes generic, preferred-brand, and nonpreferred brand drugs that are available through either a retail or mail-order pharmacy.
    - Prescription drugs purchased through retail are at a ***coinsurance*** amount with minimum and maximum ***copay*** amounts for a 30-day supply. If the actual cost of the prescription is less than the minimum ***copay***, you will pay only the actual cost of the drug. The maximum prescription supply available from any retail pharmacy is a 30-day supply.

- Prescription drugs purchased through mail order are at a flat ***copay*** amount for a 90-day supply. The Mail-Order Drug Program is through Tel-Drug. Ask your doctor about getting a mail-order prescription for maintenance drugs.

Guidelines

- You are responsible for obtaining from CIGNA HealthCare all required ***pre-certification*** or ***prior authorization*** for out-of-network medical services.
- You must obtain ***pre-certification*** or ***prior authorization*** for any out-of-network, nonemergency ***hospital*** stays before you are admitted.
- Your in-network ***provider*** will obtain any required ***pre-certification*** or ***prior authorization*** for all in-network medical services.
- Failure to follow ***pre-certification*** or ***prior authorization*** requirements results in a $300 reduction in benefits.

Member Resources

CIGNA HealthCare offers the following resources to aid members in managing their care and achieving better health.

- Members may obtain a list of network ***providers***, order ***ID*** cards, view claim history, and view ***EOBs*** by registering at www.mycigna.com.
- The Disease Management Program is a voluntary program to help members manage chronic conditions for asthma, diabetes, heart disease, low-back pain, and chronic obstructive pulmonary disease.
- Health information nurses are available 24 hours a day, seven days a week, at 1-800-564-9286.

Section 2. Eligibility

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

The following groups are eligible to enroll in this Plan:

- Active employees who are not eligible for ***Medicare primary*** coverage
- Employees who are on a ***leave of absence*** and are not eligible for ***Medicare primary*** coverage
- Retirees who are not eligible for ***Medicare primary*** coverage
- **Long-term disability terminees** who are not eligible for ***Medicare primary*** coverage
- Surviving spouses who are not eligible for ***Medicare primary*** coverage
- Covered members who elect temporary coverage under ***COBRA***.

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

Covered members who become eligible for ***Medicare primary*** coverage should enroll in ***Medicare*** Parts A and B. Once a member becomes eligible for ***Medicare primary*** coverage, Sandia will pay benefits only as secondary payer for benefits provisions under this Plan, regardless of whether the member enrolled in ***Medicare*** Parts A and B.

IMPORTANT

If a covered member *who is eligible for* ***Medicare primary*** *coverage is provided* ***primary coverage*** *under this or any other Sandia-sponsored medical* plan*, the* ***primary covered member*** *will be responsible for reimbursing Sandia for any ineligible benefits.*

Refer to the ***Medicare*** booklet *Medicare & You* for more information. You can access the booklet from ***Medicare*** at www.medicare.gov or 1-800-633-4227, or from your local Social Security office.

Employees

You, as a Sandia employee, are eligible to enroll in this Plan. If you enroll within 31 calendar days of your date of hire, your medical coverage is effective as of your hire date. The following types of Sandia employees are eligible for coverage:

- Regular, full- or part-time employees as classified by Sandia for payroll purposes

- Limited-term exempt or nonexempt employees
- Faculty sabbatical appointees not eligible for other group health care coverage
- Year-round student interns who are enrolled in a ***post-secondary educational program*** and who are not covered by another medical plan.

For purposes of coverage under this Plan, an employee is eligible only if:

- He/she has satisfied all requirements for coverage under the Plan
- Sandia withholds required federal, state, or FICA taxes from his/her paycheck
- Sandia issues him/her a W-2 for the year in which a medical service under the Plan is provided
- Sandia issues him/her the W-2 above no later than the year following the year in which the medical service was provided.

EXCEPTIONS

1. An employee receiving benefits under Sandia's Job Incurred Accident Disability Plan who does not have taxes withheld by Sandia from his/her paycheck, but who otherwise satisfies the eligibility requirements of this Plan, is an "employee" for purposes of coverage under this Plan.
2. An employee on inactive status because he/she is on a Sandia-approved ***leave of absence***, as evidenced by the written approval then required for such leave, who otherwise satisfies the eligibility requirement of this Plan, is an "employee" for purposes of coverage under this Plan.

Retirees

Members who retire and are enrolled in this Plan and are not eligible for ***Medicare primary*** coverage (under age 65) may continue ***primary coverage*** under this Plan. Retirement from Sandia is a ***qualifying event*** allowing you to change your medical plan coverage. You may change your medical plan coverage if you do so within 31 calendar days of your retirement date.

If you elect to remain enrolled in this Plan, this Plan will continue to be your ***primary coverage*** until such time that you become eligible for ***Medicare primary*** coverage.

Upon becoming eligible for ***Medicare primary*** coverage (upon reaching age 65), you have the option of enrolling in either the CIGNA Senior Premier PPO Plan or the Lovelace Senior Plan (certain NM counties only). You also have the option of dropping coverage. You must notify Sandia Benefits in writing, within 31 calendar days of becoming eligible for ***Medicare primary*** coverage of any change you decide to make.

If you do not notify Sandia Benefits within 31 calendar days of becoming eligible for ***Medicare primary*** coverage, your coverage will be defaulted to the CIGNA Senior Pre-

mier PPO Plan. Your next opportunity to select a different plan will be during the Open Enrollment period Sandia holds each fall, and coverage will be effective January 1 of the following calendar year.

All ***Medicare primary*** family members must be enrolled in the same plan, and all non-***Medicare primary*** family members must be enrolled in the same plan.

> **Note:** Retirees reaching age 65 will be sent a courtesy letter by Sandia Benefits informing them of the opportunity to enroll in ***Medicare*** and of the medical plan options available to them. However, if this letter is not received, this does not relieve the retiree of the responsibility of enrolling in ***Medicare*** Parts A and B to receive full benefits.

Long-Term Disability Terminees

Covered members who are approved for and are receiving long-term disability benefits under the Sandia Long-Term Disability (LTD) Plan or the Sandia Long-Term Disability Plus Plan may continue their ***primary coverage*** under this Plan.

This Plan will continue to be your ***primary coverage*** until such time that you become eligible for ***Medicare primary*** coverage. If you have been receiving Social Security disability benefits for 24 months or longer, you are eligible for ***Medicare primary*** coverage.

Upon becoming eligible for ***Medicare primary*** coverage, you have the option of enrolling in either the CIGNA Senior Premier ***PPO*** Plan or the Lovelace Senior Plan (certain NM counties only). You also have the option of dropping coverage under any Sandia-sponsored medical plans. You must notify Sandia Benefits in writing, within 31 calendar days of becoming eligible for ***Medicare primary*** coverage, of any change you decide to make.

If you do not notify Sandia Benefits within 31 calendar days of becoming eligible for ***Medicare primary*** coverage, your coverage under a Sandia-sponsored medical plan will be defaulted to the CIGNA HealthCare Senior Premier PPO Plan. Your next opportunity to select a different plan will be during the Open Enrollment period Sandia holds each fall, and coverage will be effective January 1 of the following calendar year.

LTD terminees include covered members (who are not eligible for ***Medicare primary*** coverage) who after January 1, 1982, became disabled before retirement and have been approved and have been receiving Sandia's long-term disability benefits.

IMPORTANT

*Terminating from Sandia is a **qualifying event** that allows you to change your medical plan when you notify Sandia Benefits, in writing, within 31 calendar days of your retirement date.*

All ***Medicare primary*** family members must be enrolled in the same plan; and all non-***Medicare primary*** family members must be enrolled in the same plan.

Other Eligible Persons

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

- Employee on certain ***leaves of absence***. An employee on inactive status because he/she is on a Sandia Corporation-approved ***leave of absence***, as evidenced by the written approval required for such leave, who otherwise satisfied the eligibility requirements of this Plan, is a covered "employee" for purposes of coverage under this Plan.
- Surviving spouse (who is not eligible for ***Medicare primary*** coverage) of a regular Sandia employee or retiree.
- Covered members who elects and pays for temporary coverage (***COBRA***) and pays the appropriate premium when required.

Eligible Dependents

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

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

In general, dependents of the ***primary covered member***, who are eligible for ***Medicare primary*** coverage, are not eligible for coverage under this Plan. Refer to the CIGNA Senior Premier ***PPO*** Plan Summary Plan Description for ***coordination of benefits*** with ***Medicare***.

Your covered dependents who become eligible for ***Medicare primary*** coverage should enroll in ***Medicare*** Parts A and B. Once your covered dependent becomes eligible for ***Medicare primary*** coverage, Sandia will pay benefits only as secondary payer for benefits provisions under the Plan, regardless of whether your covered dependents enrolled in ***Medicare*** Parts A and B.

IMPORTANT

*If your covered dependent who is eligible for **Medicare primary** coverage is provided **primary coverage** under this or any other Sandia-sponsored health plan, the **primary covered member** will be responsible for reimbursing Sandia for any ineligible benefits.*

Refer to the ***Medicare*** booklet *Medicare & You* for more information. You can access the booklet from ***Medicare*** at www.medicare.gov or 1-800-633-4227, or from your local Social Security office.

IMPORTANT

*As an employer, Sandia is obligated to accurately withhold income and employment taxes. If your plan dependent does not qualify as a dependent under **IRC** Section 152 for purposes of health coverage for the entire year, you may be subject to imputed income. Refer to Section 4. Group Health Plan Premiums for more information.*

Class I Dependents

If you are the ***primary covered member*** under this Plan, your non-***Medicare primary***, Class I dependents who are eligible for coverage under this Plan include your:

- Spouse, not legally separated or divorced from you

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

- Unmarried ***child*** under age 19, including legally adopted ***children***
- Unmarried ***child*** age 19 and over, but under age 24, who is ***financially dependent*** on you (financial dependency means that you provide more than 50 percent of his/her support for the entire calendar year)
- Unmarried ***child*** of any age who:
  - Is permanently and ***totally disabled*** and unable to engage in any substantial, gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months
  - Lives with you, in an institution, or in a home that you provide
  - Is ***financially dependent*** on you
- Unmarried ***child*** who is recognized as an ***alternate recipient*** in a ***QMCSO***.

In addition, if you are a nonrepresented or OPEIU- or SPA-represented employee and the ***primary covered member*** under this Plan, your Class I dependents eligible for coverage also include your:

- Domestic partner who meets all of the following requirements:

- Is the same gender as the ***primary covered member***
- Shares significant financial resources and dependencies
- Has resided with the ***primary covered member*** continuously for at least six months in a sole-partner relationship that is intended to be permanent
- Is unmarried
- Is not related to the ***primary covered member*** by blood (e.g., brothers, sisters, parents, ***children***, cousins, nieces, uncles)
- Is at least 18 years of age

Note: Domestic partners who attain age 65 are considered as having ***Medicare*** as their ***primary coverage*** even if enrolled as a dependent of an employee.

- Unmarried ***child*** of your eligible domestic partner under age 19, including legally adopted ***children***
- Unmarried ***child*** of your eligible domestic partner, who is age 19 and over, but under age 24, and who is ***financially dependent*** on you
- Unmarried ***child*** of your eligible domestic partner, of any age, who, because of a physical or mental impairment
  - Is permanently and ***totally disabled*** and unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months
  - Lives with the ***primary covered member***, in an institution, or in a home that is provided by the ***primary covered member***
  - Is ***financially dependent*** on the ***primary covered member***
- Unmarried ***child*** of your eligible domestic partner who is recognized as an ***alternate recipient*** in a ***QMCSO***.

Class II Dependents

If you are the ***primary covered member*** under this Plan, your Class II dependents who are eligible for coverage under this Plan include dependents who are not eligible for ***Medicare primary*** coverage and include:

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

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

Your Class II dependent may qualify for this Plan if your dependent:

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

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

Provision for Covered Members with End-Stage Renal Disease

Covered members may be eligible for ***Medicare primary*** coverage due to end-stage renal disease.

This CIGNA Premier PPO Plan may continue as your ***primary coverage*** for the first 33 months (from the time you start dialysis), which includes the 30-month coordination period with ***Medicare*** as your secondary coverage. After the 30-month coordination period, ***Medicare*** will become your ***primary coverage***.

Covered members who become eligible for ***Medicare primary*** coverage should enroll in ***Medicare*** Parts A and B. Once a covered member becomes eligible for ***Medicare primary*** coverage, Sandia will pay benefits only as secondary payer for benefits provisions under this Plan, regardless of whether the member enrolls in ***Medicare*** Parts A and B.

IMPORTANT

If a covered member *who is eligible for* ***Medicare primary*** *coverage is provided* ***primary coverage*** *under this or any other Sandia-sponsored medical plan, the* ***primary covered member*** *will be responsible for reimbursing Sandia for any ineligible benefits.*

Refer to the ***Medicare*** booklet *Medicare & You* for more information. You can access the booklet from ***Medicare*** at www.medicare.gov or 1-800-633-4227, or from your local Social Security office.

Qualified Medical Child Support Order (QMCSO)

Generally, your Plan benefits may not be assigned or alienated. However, an exception applies in the case of any ***child*** of a participant (as defined by ***ERISA***) who is recognized as an ***alternate recipient*** in a ***QMCSO***. A ***QMCSO*** is an order issued by a court or administrative agency pursuant to applicable state domestic relation laws that assigns to a ***child*** the right of a participant or beneficiary to receive benefits under an employer-provided health plan, regardless of with whom the ***child*** resides. This Plan will comply with the terms of a ***QMCSO***.

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

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

Eligibility Appeal Procedures

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

You may appeal any eligibility status determination by writing to the Sandia Employee Benefits Committee (***EBC***), Attention: Benefits Department, MS 1022, Albuquerque, NM 87185.

You must appeal to the ***EBC*** within 180 days of the date of the letter informing you of the eligibility status determination The ***EBC*** has the exclusive right to interpret eligibility. The secretary of the ***EBC*** has the authority to make the final determination for ***urgent care*** appeals. The determination of the ***EBC*** or its secretary is conclusive and binding.

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

Plan dependent eligibility based on incapacitation is determined by CIGNA HealthCare. Contact the Sandia ***HBES*** for information on applying for dependent incapacitation status.

Note: If you do not enroll a dependent because he/she has other medical coverage and your dependent involuntarily loses eligibility for that coverage, you may be able to enroll him/her in your medical plan provided that you request enrollment within 31 calendar days after the other coverage ends.

Section 3. Enrollment and Disenrollment

This section outlines the enrollment procedures for new hire employees, how to enroll and disenroll dependents, and the consequence of not disenrolling dependents in a timely manner. It also provides information on your rights under the Health Insurance Portability and Accountability Act (***HIPAA***), the option to waive or drop coverage, and the option of disenrolling and reenrolling if you take a ***leave of absence***, including a leave under the Family and Medical Leave Act (***FMLA***). For the events that may allow you to make mid-year election changes, see the ***Pre-tax Premium Plan*** booklet.

To enroll in this CIGNA Premier PPO Plan:

- Complete the medical enrollment form (SF 4400-MED) and keep a copy as proof of coverage until you receive your ***ID*** card(s) from CIGNA HealthCare.
- Complete the payroll deduction premium authorization form (SF 4811-HCC), and indicate whether you want your premium deducted on a pre-tax or after-tax basis.

Note: Refer to Section 4. Group Health Plan Premiums or consult your tax advisor for information on whether your dependent qualifies for pre-tax health benefits.

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

You must enroll in this Plan within 31 calendar days of your hire date to have coverage retroactive to your date of hire. If you don't enroll in this Plan at that time, your next opportunity will be during the Open Enrollment period Sandia holds each fall, and coverage will be effective January 1 of the following calendar year.

New Hire Employees

Newly hired Sandia employees who meet the eligibility criteria, as outlined in Section 2. Eligibility, are eligible to enroll for medical coverage under this Plan. They may also elect to enroll their eligible Class I dependents as outlined in Section 2. Eligibility.

Sandia ***HBES*** will provide a medical enrollment form (SF 4400-MED) and payroll deduction premium authorization form (SF 4811-HCC) to complete your enrollment in this Plan.

Note: You must enroll yourself and your eligible Class I dependents in this plan within 31 calendar days of your effective hire date in order to be covered from your first day of hire.

Enrolling Dependents

Enrolling Class I Dependents

All Class I dependents whom you elect to have covered under this Plan must be enrolled within 31 calendar days of the event qualifying them for coverage, such as when they are newly eligible (e.g., birth, adoption, marriage, becoming an employee). If you miss the 31-calendar-day period, the next opportunity for you to enroll your eligible Class I dependents will be during the Open Enrollment period Sandia holds each fall, and coverage will be effective January 1 of the following calendar year.

If you want to add a domestic partner or a dependent of your domestic partner to your coverage under your medical plan, refer to the Domestic Partner packet. You may obtain this packet from the Sandia Benefits internal website or contact Sandia ***HBES*** at (505) 844-4237 for assistance.

Effective dates of coverage for your Class I dependents, enrolled within 31 calendar days of their ***qualifying event***, are as follows:

Dependent Due to	Effective Date of Coverage
Marriage	Later of the date of the event creating eligibility or the date Benefits receives completed paperwork
Legal Guardianship	Later of the date of the event creating eligibility or the date Benefits receives completed paperwork
Birth	Retroactive coverage to the date of the event (birth)
Adoption	Retroactive coverage to the date of the event (adoption). **Note:** Medical expenses of the child before adoption, including the birth mother's prenatal, postnatal, and delivery charges, are not covered.
Placement for Adoption	Retroactive coverage to the date of the event (placement). **Note:** Medical expenses of the child before placement, including the birth mother's prenatal, postnatal, and delivery charges, are not covered.

IMPORTANT

*A marriage or birth certificate is required within 60 calendar days of the **qualifying event** (marriage or birth) to verify eligibility to enroll your new dependent.*

If you do not provide the marriage or the birth certificate for your new dependent, your dependent will be disenrolled and will have coverage for only the first 60 calendar days beginning with the effective date of coverage.

Submit your documentation to Sandia Benefits at MS 1022.

All dependent information requested on the medical enrollment form (SF 4400-MED) must be provided, including:

- Dependent's complete name and relationship to you
- Social Security number (not applicable to newborns)
- Date of birth and gender

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

Other Insurance Request for Dependents

Beginning January 1 of every year, or if you are a new enrollee, CIGNA HealthCare will require an update on whether any of your covered dependents have other insurance. This information must be provided even if your dependents do not have other insurance. If you do not provide this information, CIGNA HealthCare will put a hold on your dependents' claims and request other insurance verification, in writing, from the ***primary covered member***. You may update the other insurance information through www.mycigna.com or by calling CIGNA HealthCare at 1-800-244-6224.

Enrolling Class II Dependents

All Class II dependents whom you elect to have covered under this Plan must be enrolled within 31 calendar days of the event qualifying them for coverage, such as when they are newly eligible (financial dependence, etc.). If you miss the 31-calendar-day period, the next opportunity for you to enroll your eligible Class II dependents will be during the Open Enrollment period Sandia holds each fall, and coverage will be effective on January 1 of the following year.

If you want to add a domestic partner or a dependent of your domestic partner to your coverage under your medical plan, refer to the Domestic Partner packet. You can obtain this packet on Sandia Benefit's internal web or contact Sandia ***HBES*** at (505) 844-4237.

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

Class II Dependent	Effective Date of Coverage
Unmarried child or step-child	Later of the date of the event creating eligibility or the date Benefits receives completed paperwork
Unmarried grandchild	Later of the date of the event creating eligibility or the date Benefits receives completed paperwork Note: If eligible due to birth or adoption or placement for adoption, the effective date is the date of the event.

Class II Dependent	Effective Date of Coverage
Unmarried brother or sister	Later of the date of the event creating eligibility or the date Benefits receives completed paperwork
Your or your spouse's, parent, stepparent, or grandparent	Later of the date of the event creating eligibility or the date Benefits receives completed paperwork

IMPORTANT

*A marriage or birth certificate is required within 60 calendar days of the **qualifying event** (marriage or birth) to verify eligibility to enroll your new dependent.*

If you do not provide the marriage or the birth certificate for your new dependent, your dependent will be disenrolled and will have coverage for only the first 60 calendar days beginning with the effective date of coverage.

All dependent information requested on the medical enrollment form (SF 4400-MED) must be provided, including:

- Dependent's complete name and relationship to you
- Social Security number (not applicable to newborns)
- Date of birth and gender

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

In addition, in order to enroll a Class II dependent, you must complete the Application for Sandia Medical Care Plan Coverage for Class II dependents form (SF 4400-CTD)**,** which includes a Class II Dependent Affidavit. Mail the form to Sandia ***HBES*** in adequate time to be received by the 31 calendar day requirement for enrollment.

You will be required every December to complete the Class II Dependent Affidavit to continue coverage for your Class II dependent(s) for the next calendar year. This form must be received by Sandia ***HBES*** by December 31 to continue coverage for the next calendar year.

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

Disenrolling Dependents

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

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

All ineligible dependents must be disenrolled within 31 calendar days of the event that has made them no longer eligible for this Plan. Coverage ends at the end of the month in which the dependent became ineligible.

If your premium deductions are on an after tax basis, you can disenroll your dependents at any time without a ***mid-year election change event***; however, you can only reenroll them with a ***mid-year election change event*** or during Open Enrollment.

If your premium deductions are on a pre-tax basis, you can disenroll your dependents within 31 calendar days of a ***mid-year election change event*** allowing a mid-year election change or during the Open Enrollment period Sandia holds each fall. If the disenrollment of the dependent does not affect your premium-share amount, you can disenroll dependents at any time during the calendar year.

Events Causing Your Dependent to Become Ineligible

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

Class I

- Divorce or annulment
- Dissolution of domestic partnership
- Legal separation
- ***Child*** marries
- ***Child*** no longer ***financially dependent***
- ***Child*** no longer meets the age criteria
- Incapacitated ***child*** no longer meets incapacitation criteria
- ***Child*** no longer meets the Class I criteria
- ***Child*** is no longer covered under ***QMCSO***

Class II

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

How to Disenroll Dependents

- Complete the dependent disenrollment form (SF 4400-DIS)

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

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

IMPORTANT

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

Benefits forms are available on Sandia's website under Corporate Forms/Benefits or by calling Sandia ***HBES*** at (505) 844-4237.

Note: You can disenroll a dependent without a ***mid-year election change event*** if you are NOT enrolled in the ***Pre-tax Premium Plan***.

Sandia abides by a federal law known as the Consolidated Omnibus Budget Reconciliation Act (***COBRA***) of 1985 in which temporary continued coverage is provided to dependents who would otherwise lose group coverage due to specified events. Refer to Section 13. Continuation of Group Health Coverage for more information.

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

Consequence of Not Disenrolling Ineligible Dependents

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

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

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

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

- Retroactively terminate dependent coverage, effective the end of the month in which the dependent became ineligible
- Refund any applicable premium paid by you during the ineligible period

- Hold the ***primary covered member*** personally liable to refund to Sandia all Plan benefits provided during the ineligible period
- Terminate any rights to temporary, continued health care coverage under ***COBRA***

HIPAA Rights

HIPAA provides rights and protections for participants and beneficiaries in group health plans. Under ***HIPAA***, if you waived or dropped coverage for yourself and your covered dependents because of other health insurance coverage, and you and/or your covered dependents involuntarily lose eligibility for that coverage, you may be able to enroll yourself and your eligible dependents during the plan year. You must request enrollment, and notify Benefits in writing, within 31 calendar days of your loss of coverage.

IMPORTANT

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

The eligible events that may allow a mid-year election to enroll in this Plan include:

- **Loss of eligibility under another plan.** An eligible employee or retiree (and/or his/her dependents) who declined coverage when initially eligible because of having other medical coverage, and who later loses the other coverage, may apply for coverage within 31 calendar days of the loss of coverage.
- ***COBRA* is exhausted after coverage under another medical plan.** An eligible employee or retiree (and/or his/her dependents) who has exhausted coverage under another medical plan outside Sandia may apply for coverage within 31 calendar days of this event.
- **Employer contributions to other coverage ends.** An eligible employee or retiree (and/or his/her dependents) whose employer contributions to the other plan in which he/ she is enrolled have ended may apply for coverage within 31 calendar days of the date the other coverage ends.
- **Exhausting a lifetime limit under another plan.** An eligible employee or retiree (and/or his/her dependents) who has exhausted coverage under another plan due to meeting lifetime limits may apply for coverage within 31 calendar days of the date coverage is denied due to meeting the lifetime limit.

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

Waiving or Dropping Coverage in Sandia-Sponsored Health Plans

IMPORTANT

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

You have the option to waive or drop coverage for yourself and your dependents. You may waive coverage when you initially become eligible to enroll in the plan, or you can elect to drop coverage during the annual Open Enrollment period Sandia holds each fall.

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

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

How to Waive or Drop Coverage

- Complete the waiver of medical coverage form (SF 4811-WMC)
- Retain a copy for your files
- Mail the original, early enough to meet the 31-calendar-day criteria or the end of the Open Enrollment period, to Sandia Benefits at Mail Stop 1022.

Benefits forms are available on Sandia's website under Corporate Forms/Benefits or by calling Sandia ***HBES*** at (505) 844-4237.

Coverage During Leaves of Absence

Employees meeting the requirements of the ***FMLA*** have the option to cancel their coverage under this Plan. Written notification to cancel coverage must be received by Sandia Benefits, in writing, within 31 calendar days of the first day of absence. If you choose to cancel coverage, coverage will cease at the end of the month in which Sandia Benefits receives written notification. If you do not cancel the coverage, coverage will be continued and premiums will continue to be deducted during your absence, or made up upon your return from an unpaid absence.

Employees taking a non-***FMLA*** leave will receive paperwork from Sandia Benefits. If you wish to continue coverage under this Plan, you will be responsible for paying your monthly premiums on an after-tax basis. If you do not continue to pay your premiums during a non-***FMLA*** leave, your coverage will be canceled.

If you do not cancel your coverage under this Plan during your ***leave of absence*** or unpaid absence and you return in a subsequent calendar year, premiums not taken will be made up on an after-tax basis.

An employee can reenroll in this Plan by requesting enrollment and notifying Sandia Benefits, in writing, within 31 calendar days of returning to work from the ***leave of absence***. If you do not reenroll in this Plan by notifying Sandia Benefits, in writing, within 31 calendar days of your date of return from leave, you cannot reinstate your medical coverage until the following Open Enrollment period Sandia holds each fall.

IMPORTANT

If you waived health coverage for yourself and your dependents while still employed with Sandia, and you then terminate employment with Sandia without health coverage, you and your dependents are not eligible for any ***COBRA*** *continuation.*

Mid-Year Election Change Events

Mid-year election change events (exceptions include moving into or out of the service area or as described in Section 13. Continuation of Group Health Coverage) do not allow you to change from one medical plan to another medical plan sponsored by Sandia. Changes in medical plan elections are allowed during the annual Open Enrollment period held each fall by Sandia.

Certain qualifying events may permit a mid-year election change to your medical care coverage such as the enrollment of a newly eligible dependent or the disenrollment of a dependent child who marries and no longer eligible for coverage under your plan. Refer to the ***Pre-tax Premium Plan*** booklet for more information on mid-year election change events.

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

Section 4. Group Health Plan Premiums

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

Benefits paid under a group health plan for your covered dependents who would not qualify as a tax dependent under the Internal Revenue Code (***IRC***) for purposes of health coverage causes the ***primary covered member*** to receive additional compensation as taxable wages.

The ***primary covered member*** is required to declare as taxable income the value (imputed income) of the coverage for the noneligible dependent. Imputed income is not a pay increase. It is the value of Sandia's contributions for health coverage for dependents who are not your tax dependents. The imputed income will be added to your gross income and will be subject to income taxes and may be subject to FICA (Social Security and ***Medicare***) and income taxes. This amount will be reported on your annual W-2 from Sandia or other appropriate reporting tax form.

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

If any of your covered dependents do not meet the definition of tax dependent, as set forth in the ***IRS*** for purposes of health coverage, contact Sandia ***HBES*** at (505) 844-4237 to obtain a form to complete so that your dependents can be reflected correctly in the database. Refer to the ***Pre-tax Premium Plan*** booklet for more information. In addition, in some instances, you will also incur imputed income for those premiums paid prior to your dependent not qualifying as your tax dependent for the calendar year.

IMPORTANT

*It is the responsibility of each **primary covered member** to determine if his/her covered dependent meets the plan eligibility requirement of Sandia's medical plans and the tax dependent rules of the **IRC**. Should the **IRS** audit your tax return and determine you have obtained tax benefits for which you are not eligible, you will be responsible for any overdue taxes, interest, and penalties.*

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

Monthly Premium Payment for Coverage

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

- Employee's biweekly paycheck in two equal installments each month or
- Retiree's monthly pension check

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

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

Other eligible covered persons pay

- In a direct payment to Sandia

Note: Premiums for health care coverage are not allowed as reimbursable expenses under the ***Health Care Reimbursement Spending Account***.

Employee Premium

The premiums for coverage under this Plan are provided during the Open Enrollment period Sandia holds each fall prior to the start of the plan year. Employees may also contact Sandia ***HBES*** at (505) 844-4237 for premium-share informaton for coverage.

All employees pay a monthly premium for coverage under this Plan. Employees' monthly premium payments are set according to the employee's base salary tier, coverage tier, and the plan coverage elected by the employee. Class I dependent premiums are included in the employee premium share amount taken through payroll deductions.

The premium share for coverage is set according to the following family structure:

- Employee Only
- Employee and ***child(ren)***
- Employee and Spouse
- Employee, Spouse, and ***child(ren)***

Sandia currently has three salary tiers for premium share purposes:

- Tier 1 – Base salary of up to $75,000 as of January 1

- Tier 2 – Base salary of $75,001 to $150,000 as of January 1
- Tier 3 – Base salary of over $150,000 as of January 1

The premium share for the calendar year is based on your base salary as of January 1. If your base salary changes during the year and you are bumped into another tier, your premium share will not change for the remainder of the calendar year.

Employees working on a part-time basis (at least 24 hours per week) pay the applicable premium share based on their pro-rated salary as of January 1; however, part-time employees working less than 24 hours per week will pay one-half of the full premium cost (regardless of when they began the work schedule of less than 24 hours per week).

Note: Represented employees need to refer to their union agreements for premium-sharing information.

If your effective coverage date is prior to the 17th of the month, you are required to pay the applicable cost-share amount for the month in which you became eligible for coverage under this Plan. If your effective coverage date is on the 17th of the month or later, you are not required to pay the cost-share amount for the month in which you became eligible for coverage under this Plan.

Dual Sandians

If you are a Sandia employee married to another Sandia employee or to a Sandia retiree, you are considered a ***dual Sandian***. You, as a ***dual Sandian***, may elect to cover yourself as (1) an individual, or (2) a dependent of your Sandia spouse, or (3) as the primary covered employee or retiree with your Sandia spouse as a dependent. If you, as the employee, are the ***primary covered member***, cost-sharing of monthly premiums will be based on your salary tier.

If you and your Sandia spouse (***dual Sandians***) elect to be covered separately, any eligible dependents may be covered under either spouse (i.e., some dependents may be enrolled under one spouse while other dependents are enrolled under the other spouse). Dependents may NOT be covered under both Sandians simultaneously.

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

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

Class II Premium

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

The ***Pre-tax Premium Plan*** allows employees to take advantage of the tax savings generated by having any required medical care premiums taken out of their paychecks before federal, state, and social security (FICA) taxes are deducted. Your taxable income is reduced because your premiums are not included as income. This is allowable under Section 125 of the ***IRS*** Code.

Once the calendar year has started, you generally cannot change the tax status (that is, from pre-tax to after-tax and vice versa) of your premium share. However due to ***IRS*** rules governing pre-tax premiums, individuals not qualifying as tax dependents under the ***IRC*** for purposes of medical care coverage must be enrolled individually and cannot be combined as part of the Employee and Spouse; Employee and ***child(ren)***; or Employee, Spouse, and ***child(ren)*** coverage. Separate monthly premiums must be paid to cover these individuals on an after-tax basis. However, if your dependent becomes ineligible as a tax dependent under ***IRC*** rules for purposes of health care coverage but is still eligible under the health care plans, your pre-tax premiums attributable to that dependent's coverage will be changed to after tax, as you may not pay any portion of their monthly premiums for medical coverage on a pre-tax basis through the ***Pre-tax Premium Plan***.

If you elect to have premiums taken on a pre-tax basis for your Class II dependents, and you have a plan dependent who does not meet Section 152 of the ***IRC*** for purposes of medical care coverage, you must notify Sandia ***HBES***, as the premium (if applicable) for that dependent will need to be paid on an after-tax basis, and you will have imputed income. If your dependent does not meet the eligibility criteria for plan coverage, you must disenroll him/her within 31 calendar days. Refer to the ***Pre-tax Premium Plan*** booklet for more information.

Domestic Partner Premium

For health coverage purposes under the ***IRC***, benefits for a covered domestic partner, or for covered dependents of a domestic partner who do not qualify as a tax dependent under the ***IRC***, causes the ***primary covered member*** to receive additional compensation as taxable wages.

The employee is required to declare as taxable income the value (imputed income) of the coverage for the domestic partner and his/her dependents. Imputed income is not a pay

increase. It is the value of Sandia's contributions for health coverage for dependents who are not employee's tax dependents. The imputed income will be added to the employee's gross income and will be subject to income tax and may be subject to FICA (Social Security and ***Medicare***) and income taxes. This amount will be reported on the employee's annual W-2 from Sandia or other appropriate reporting tax form.

> **Note:** Premiums for your domestic partner and/or your domestic partner's dependents will be automatically deducted on an after-tax basis. Imputed income will be included in the employee's income UNLESS he/she contacts Sandia Benefits and completes an Affidavit of Tax Status to allow those dependents discussed above to be designated as tax dependents under ***IRC*** 152 for medical coverage purposes.

For information on specific premium-sharing provisions for domestic partners, refer to the Domestic Partner packet on the Benefits internal web, or contact Sandia ***HBES*** at (505) 844-4237 to obtain a packet.

Pre-Tax Premium Plan

The ***Pre-tax Premium Plan*** (***PTPP***) allows employees to take advantage of the tax savings generated by having health coverage premiums taken out of their paychecks before federal, state, and Social Security (FICA) taxes are deducted. Your taxable income is reduced because your premiums are not included as income. This is allowable under Section 125 of the ***IRS*** code. Once the calendar year begins, you generally cannot change the tax status (from pre-tax to after-tax and vice versa) of your premium share.

Due to ***IRS*** rules governing pre-tax premiums, individuals not qualifying as tax dependents under ***IRC*** for purposes of medical coverage must be enrolled individually and cannot be combined as part of the Employee and Spouse, Employee and ***child(ren)***, or Employee, Spouse, and ***child(ren)*** coverage.

Separate monthly premiums must be paid to cover these individuals on an after-tax basis. If your dependent becomes ineligible as your tax dependent under the ***IRC*** rules for purposes of health care coverage, but he/she is still eligible under this Plan, your pre-tax premiums attributable to the dependent's health coverage will be changed to after-tax as you may not pay any portion of health coverage premiums on a pre-tax basis for dependents who do not qualify as your tax dependent for medical coverage purposes.

> **Note:** Check your pay stub to determine whether premiums are being taken on a pre-tax or after-tax basis.

IMPORTANT

*You must notify Sandia Benefits of premiums being taken on a pre-tax basis for your dependents who do not meet the dependent criteria of Section 152 of the **IRC** for medical coverage purposes. The health coverage premiums (if applicable) for these dependents will need to be paid on an after-tax basis; and you will have imputed income.*

*If your dependent does not meet the eligibility criteria for plan coverage, you must disenroll him or her within 31 calendar days of becoming ineligible. Refer to the **Pre-tax Premium Plan** booklet for more information.*

Leaves of Absence

Child Care and Family Care: Sandia pays the employer portion of the premiums for continued medical coverage under this Plan during the first six months of this leave. You will pay the full premium for continued medical coverage beyond the first six months.

If you do not continue your medical coverage under this Plan during your leave, you will need to reenroll to reinstate your medical coverage under this Plan.

Tribal Government Appointees: Sandia pays the employer portion of the premiums for continued medical coverage under this Plan during this leave.

If you do not continue your medical coverage under this Plan during your leave, you will need to reenroll to reinstate your medical coverage under this Plan.

Military Service: Sandia pays the employer portion of the premiums for continued medical coverage during the first six months of this leave. You will pay the full premium for continued medical coverage beyond the first six months.

If you do not continue your medical coverage under this Plan during your leave, you will need to reenroll to reinstate your medical coverage under this Plan.

All Other: Your medical coverage under this Plan stops at the end of the month in which your leave begins. You are eligible to continue your medical coverage under this Plan by paying the full premium for the duration of your approved leave.

If you do not continue your medical coverage under this Plan during your leave, you will need to reenroll to reinstate your medical coverage under this Plan.

Premiums for Retiree Medical Plan Option

The premiums for continued medical care coverage under this Plan are provided during the Open Enrollment period Sandia holds each fall prior to the start of the plan year. You may also contact Sandia ***HBES*** at (505) 844-4237 for premium-share information.

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

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

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

- Retirees who retired after December 31, 1994, and before January 1, 2003, will pay 10 percent of the experience-rated premiums.
- Retirees who retired after December 31, 2002, will pay a percentage of the experience-rated premiums based on their term of employment as follows:
  - 30+ years – 10 percent
  - 25 to 29 – 15 percent
  - 20 to 24 – 25 percent
  - 15 to 19 – 35 percent
  - 10 to 14 – 45 percent

Retirees who do not meet any of the above conditions may continue coverage under this Plan by paying the full cost of coverage under ***COBRA***. Refer to Section 13. Continuation of Group Health Coverage for more information.

Dual Sandians

If you are a Sandia retiree married to another Sandia retiree or to a Sandia employee, you are considered a ***dual Sandian***. You, as a ***dual Sandian***, may elect to cover yourself as (1) an individual, or (2) a dependent of your Sandia spouse, or (3) as the primary covered employee or retiree with your Sandia spouse as a dependent. If you, as the retiree, are the ***primary covered member***, cost-sharing of monthly premiums will be based on retiree status. If you and your Sandia spouse elect to be covered separately, any eligible dependents may be covered under either spouse (i.e., some dependents may be enrolled under

one spouse while other dependents are enrolled under the other spouse). No dependents may be covered under both Sandians simultaneously.

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

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

Premiums for Long-Term Disability (LTD) Terminees

The premiums for continued medical care coverage for LTD terminees under this Plan are provided during the Open Enrollment period Sandia holds each fall prior to the start of the plan year. LTD terminees may also contact Sandia ***HBES*** at (505) 844-4237 for premium-share information.

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

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

Premium for Surviving Spouse Medical Plan Option

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

IMPORTANT

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

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

- 50 percent of the full experience-rated premium if you are a survivor of a retiree or an employee with a 15- year term of employment.
- 100 percent of the full experience-rate premium if you are a survivor of an employee with less than a 15-year term of employment.

Your decision for continuation of coverage under the Surviving Spouse Medical Plan Option must be made prior to the expiration of the initial six-month coverage.

The applicable survivor premium share will depend on the medical care plan under which you are covered and whether coverage is for single coverage or family coverage.

Coverage under the Surviving Spouse Medical Plan Option will terminate for the surviving spouse and dependents if:

- Surviving spouse remarries

Note: If the surviving spouse remarries, he/she does not have ***COBRA*** rights to continue coverage; however, any covered dependent that would lose coverage as a result of the remarriage would have ***COBRA*** rights.

- Payments are not received when due
- Surviving spouse dies

Note: If the surviving spouse dies less than 36 months after the employee or retiree dies, covered dependents may have rights to ***COBRA*** continuation.

The ***primary covered member*** will be responsible for any claims paid on his/her behalf and any dependents' behalf as of the date of ineligibility. Contact Sandia ***HBES*** at (505) 844-4237 for more information.

COBRA Premium

Sandia requires persons who elect continuation of the employer-provided health coverage to pay the full cost of the coverage, plus a two percent administrative charge. The required ***COBRA*** premium is more expensive than the amount that active employees are required to pay but may be less expensive than individual medical coverage. ***COBRA*** continuation coverage lasts only for a limited period of time. See Section 13. Continuation of Group Health Coverage for more information.

As an alternative to electing medical coverage under the Retiree, LTD Terminee, or Surviving Spouse Medical Plan Options, those individuals may choose to continue the active employee medical coverage by making a ***COBRA*** election. See Section 13. Continuation of Group Health Coverage for more information.

Section 5. Deductibles and Maximums

General Information

This section and the following tables summarize the annual ***deductibles***, ***out-of-pocket maximums***, and lifetime maximums that apply under the in-network and out-of-network options.

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

Deductibles for Employees

When self-directing care out-of-network, the member must first pay the annual ***deductible*** before the Plan begins to pay for covered medical care services. When the member meets the full ***deductible*** amount, the Plan begins to pay for eligible, covered expenses at the applicable ***coinsurance*** amount.

	In-Network Option			Out-of-Network Option		
Annual Deductible	Individual	Family of two	Family of three or more	Individual	Family of two	Family of three or more
	N/A	N/A	N/A	$500	$1,000	$1,500

Payments Not Applied to Deductible

Copayments, amounts above ***eligible expenses***, charges not covered by the Plan, prescription drug ***copays***, and charges incurred because of failure to obtain required ***pre-certifications*** or ***prior authorization*** do not apply toward the ***deductible***. Copayments are not subject to the ***deductible***, thus you do not need to meet the deductible for office visits to your PCP or specialist.

Family Deductible

Each family member may contribute toward the family ***deductible*** based on Plan usage. However, contribution maximums are limited to the individual ***deductible*** amount.

After three members in a family of three or more meet the individual ***deductible***, the family ***deductible*** is satisfied. No more than the individual ***deductible*** amount will be applied to the family maximum per member.

Example: An employee has a family of five members. The out-of-network ***deductible*** for this family is $1,500. During the calendar year, the father and mother each incurred out-of-network expenses of $500 and $200, respectively. The three ***children*** incurred out-of-network expenses as follows: first ***child***–$500; second ***child***–$300; and third ***child***–$200. These expenses are determined to be ***covered charges*** and are applied to the ***deductible*** by CIGNA HealthCare in the order of receipt of the claims. The individuals contribute to the ***deductible*** as follows:

Out-of-Network Deductible Example			
	Expenses Incurred	**Individual Plan Limit**	**Allowable Contribution**
Father	$500	$500	$500
Mother	$200	$500	$200
1st Child	$500	$500	$500
2nd Child	$300	$500	$300
3rd Child	$200	$500	$0
Total:			**$1,500**

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

Deductibles for Retirees/Survivors/LTD Terminees

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

	In-Network Option			**Out-of-Network Option**		
Annual Deductible	Individual	Family of two	Family of three or more	Individual	Family of two	Family of three or more
	$250	$500	$750	$750	$1,500	$2,500

Payments Not Applied to Deductible

Copayments, amounts above ***eligible expenses***, charges not covered by the Plan, prescription drug ***copays***, and charges incurred because of failure to obtain required ***precertifications*** or ***prior authorization*** do not apply toward the ***deductible***. Copayments are

not subject to the ***deductible***, thus you do not need to meet the deductible for office visits to your PCP or specialist.

Family Deductible

Each family member may contribute toward the family ***deductible*** based on Plan usage. However, contribution maximums are limited to the individual ***deductible*** amount.

After three members in a family of three or more meet the individual ***deductible***, the family ***deductible*** is satisfied. No more than the individual ***deductible*** amount will be applied to the family maximum per member.

Example: A retiree has coverage consisting of himself and his spouse. The in-network ***deductible*** for this family is $500. During the calendar year, the retiree and his spouse have each incurred in-network expenses of $1,000. These expenses are determined to be ***covered charges*** and are applied to the ***deductible*** by CIGNA HealthCare in the order of receipt of the claims. Each member contributes to the ***deductible*** as follows:

In-Network Deductible Example			
	Expenses Incurred	**Individual Plan Limit**	**Allowable Contribution**
Retiree	$1,000	$250	$250
Spouse	$1,000	$250	$250
Total:			**$500**

Example: A retiree has coverage consisting of himself and his spouse. The in-network ***deductible*** for this family of two is $500. During the calendar year, the retiree has incurred in-network expenses of $1,000 while his spouse incurs none. These expenses are determined to be ***covered charges*** and are applied to the ***deductible*** by CIGNA HealthCare in the order of receipt of the claims. Each member contributes to the ***deductible*** as follows:

In-Network Deductible Example			
	Expenses Incurred	**Individual Plan Limit**	**Allowable Contribution**
Retiree	$1,000	$250	$250
Spouse	$0	$0	$0
Total:			**$250**

In this example, after the retiree has met his individual ***deductible***, no additional charges are applied to his ***deductible***. The Plan will begin to cover ***eligible expenses*** at 100 percent for the retiree only. The spouse still needs to meet her individual deductible.

Out-of-Pocket Maximums for Employees

	In-Network Option		Out-of-Network Option	
Annual Out-of-Pocket Maximum	Individual	Family of two or more	Individual	Family of two or more
	$1,500	$3,000	$3,000	$6,000

With some exceptions (listed below), no additional ***coinsurance*** will be required for the remainder of the calendar year as follows:

- For the member**,** when he/she uses the in-network option and has incurred his/her in-network, ***out-of-pocket maximum*** for covered medical expenses
- For the family, when they use the in-network option and have incurred their in-network, ***out-of-pocket maximum*** for covered medical expenses
- For the member**,** when he/she uses the out-of-network option and has incurred his/her out-of-network, ***out-of-pocket maximum*** for covered medical expenses
- For the family, when they use the **out-of-network** option and have incurred their out-of-network, ***out-of-pocket maximum*** for covered medical expenses.

IMPORTANT

*The **out-of-pocket maximums** do not cross apply between in-network and out-of-pocket. CIGNA HealthCare will notify* members *via an **EOB** when the **out-of-pocket maximum** has been reached.* Members *can also get their **out-of-pocket maximums** at www.mycigna.com.*

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

Plan Features	Applies to In-Network Out-of-Pocket Maximum	Applies to Out-of-Network Out-of-Pocket Maximum
Copays	No	Not applicable
Payments toward the annual deductible	Not applicable	Yes
Member coinsurance payments	Yes	Yes
Charges for noncovered health services	No	No
Amounts of any reductions in benefits incurred by not following prior authorization or pre-certification requirements	No	No

Plan Features	Applies to In-Network Out-of-Pocket Maximum	Applies to Out-of-Network Out-of-Pocket Maximum
Amounts paid toward behavioral health services	Yes	No
Charges that exceed eligible expenses	Not applicable	No
Prescription Drug Progam	No	No

Example: In a calendar year, a family of three meets the in-network family $3,000 ***out-of-pocket maximum*** as follows:

Out-of-Pocket Maximum In-Network Example			
	Out-of-Pocket Expenses In-Network	Applied to Out-of-Pocket In-Network	Applied to Out-of-Pocket Out-of-Network
Employee	$1,500	$1,500	$0
Spouse	$1,500	$1,500	$0
1st Child	$0	$0	$0
Total:	**$3,000**	**$3,000**	**$0**

For the remainder of the calendar year, any additional covered medical expenses submitted by this family under the in-network option will be paid at 100 percent of the ***eligible expense*** (with some exceptions). If any member of this family, however, seeks out-of-network care, the in-network, ***out-of-pocket maximum*** will not apply.

Example: In a calendar year, a family of three meets the out-of-network family $6,000 ***out-of-pocket maximum*** as follows:

Out-of-Pocket Maximum Out-of-Network Example			
	Out-of-Pocket Expenses Out-of-Network	Applied to Out-of-Pocket Out-of-Network	Applied to Out-of-Pocket In-Network
Spouse	$2,000	$2,000	$0
1st Child	$3,000	$3,000	$0
2nd Child	$1,000	$1,000	$0
Total:	**$6,000**	**$6,000**	**$0**

For the remainder of the calendar year, any additional covered medical expenses submitted by this family under the out-of-network option will be paid at 100 percent of ***eligible expense*** charges (with some exceptions). If any member of this family, however, seeks in-network care, the out-of-network ***out-of-pocket maximum*** will not apply.

Out-of-Pocket Maximums for Retirees/Survivors/ LTD Terminees

	In-Network Option		Out-of-Network Option	
Annual Out-of-Pocket Maximum	Individual	Family of two or more	Individual	Family of two or more
	$1,750	$3,500	$3,500	$7,000

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

- For the member when he/she uses the in-network option and has incurred his/her in-network ***out-of-pocket maximum*** for covered medical expenses
- For the family when they use the in-network option and have incurred their in-network, ***out-of-pocket maximum*** for covered medical expenses
- For the member when he/she uses the out-of-network option and has incurred his/her out-of-network ***out-of-pocket maximum*** for covered medical expenses
- For the family when they use the out-of-network option and have incurred their out-of-network, ***out-of-pocket maximum*** for covered medical expenses.

IMPORTANT

*The **out-of-pocket maximums** do not cross apply between in-network and out-of-network. CIGNA HealthCare will notify* members *via an **EOB** when the **out-of-pocket maximum** has been reached.* Members *may also get **out-of-pocket maximums** at* www.mycigna.com.

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

Plan Features	Applies to In-Network Out-of-Pocket Maximum	Applies to Out-of-Network Out-of-Pocket Maximum
Copays	No	Not applicable
Payments toward the annual deductible	Yes	Yes
Member coinsurance payments	Yes	Yes
Charges for noncovered health services	No	No

Plan Features	Applies to In-Network Out-of-Pocket Maximum	Applies to Out-of-Network Out-of-Pocket Maximum
Amounts of any reductions in benefits incurred by not following prior authorization or pre-certification requirements	No	No
Amounts you pay toward behavioral health services	Yes	No
Charges that exceed eligible expenses	Not applicable	No
Prescription Drug Program	No	No

Example: In a calendar year, a family of two meets the in-network family $3,500 ***out-of-pocket maximum*** as follows:

Out-of-Pocket Maximum In-Network Example			
	Out-of-Pocket Expenses Out-of-Network	Applied to Out-of-Pocket In-Network	Applied to Out-of-Pocket Out-of-Network
Retiree	$1,750	$1,750	$0
Spouse	$1,750	$1,750	$0
Total:	**$3,500**	**$3,500**	**$0**

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

Example: In a calendar year, a family of two meets the out-of-network family $7,000 ***out-of-pocket maximum*** as follows:

Out-of-Pocket Maximum Out-of-Network Example			
	Out-of-Pocket Expenses Out-of-Network	Applied to Out-of-Pocket Out-of-Network	Applied to Out-of-Pocket In-Network
Retiree	$3,500	$3,500	$0
Spouse	$3,500	$3,500	$0
Total:	**$7,000**	**$7,000**	**$0**

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

Lifetime Maximums

The Plan does not have any lifetime maximums with the exception of the infertility benefit as described below.

Reaching the Infertility Maximum of $30,000

When the covered member reaches the $30,000 lifetime maximum benefit, no additional reimbursement for any infertility treatment is payable. Other covered procedures related to family planning or reproduction (excluding infertility) may be payable. Refer to Section 6. Coverages/Limitations for more information.

IMPORTANT

Retirees, survivors, and LTD terminees and their covered dependents are not eligible for the infertility benefit.

Section 6. Coverages and Limitations

This CIGNA Premier PPO provides a wide range of medical care services for you and your family. All coverage is based on medical necessity and whether the service is a ***covered health service*** as defined below. The following table details coverage under this Plan. The in-network option requires you to obtain care from a CIGNA HealthCare/ CIGNA Behavioral Health ***provider***. The out-of-network option allows you to seek care from any licensed ***provider***. For detailed explanations of what is covered under the benefit, refer to the coverage details following the table.

This Plan 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 under this Plan, there is no waiting period before you are covered under this Plan.

Covered healthy services are those health services and supplies:

- Provided for the purpose of preventing, diagnosing, or treating ***illness***, ***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 SPD)
- Provided to a covered member who meets the Plan's eligibility requirements as described in Section 2. Eligibility.

Plan Highlights

The following tables highlight the amounts you will pay for various ***covered health services***. A ***copayment*** is a cost-sharing feature by which the Plan pays the remainder of the ***covered charge*** after the member pays his/her portion as a defined dollar amount (e.g., $15 ***copay*** for ***primary care physician's*** office visit).

Note: ***Copayments*** are not subject to the ***deductible***.

Coinsurance is a cost-sharing feature by which both the Plan and the member pay a percentage of the covered ***eligible expense***. For in-network services, the ***coinsurance*** (e.g., 15 percent) is the percentage of ***eligible expenses*** you pay (after the ***deductible*** has been met, if applicable). For out-of-network service, the ***coinsurance*** (e.g., 30 percent) is the percentage of the covered ***eligible expense*** you pay after the ***deductible*** has been met.

IMPORTANT

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

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

IMPORTANT

Some services require ***pre-certification/prior authorization****. The* member *must obtain the required* ***pre-certification*** *or* ***prior authorization*** *for out-of-network services by calling CIGNA HealthCare at 1-800-244-6224. You will receive a reduced benefit of $300 or, in certain cases, no benefits without the required* ***pre-certification*** *or* ***prior authorization****.*

Benefit	In-Network Option	Out-of-Network Option
IMPORTANT *For coverage detail, please refer to the information following this table.*		
Acupuncture Services	15%	30%
Allergy Services – office visit – testing – serum – allergy shot	 $15 copay if PCP; $25 if specialist $15 copay if PCP; $25 if specialist 15% 15%	 30% 30% 30% 30%
Ambulance	15%	30%
Behavioral Health (Mental Health & Substance Abuse Program)	15%	50% (does not apply to out-of-pocket maximum)
Biofeedback Services	15%	30%
Chemotherapy – physician's office – outpatient facility – inpatient facility	 15% 15% 15%	 30% 30% 30%
Chiropractic Services	15%	30%
Dental Services – physician's office – outpatient facility – inpatient facility	 $25 copay per visit 15% 15%	 30% 30% 30%

Benefit	In-Network Option	Out-of-Network Option
IMPORTANT *For coverage detail, please refer to the information following this table.*		
Diagnostic Tests – physician's office – outpatient facility – inpatient facility	 15% 15% 15%	 30% 30% 30%
Durable Medical Equipment	15%	30%
Emergency Room Care	15%	15% for true emergency 30% for nonemergency
Employee Assistance Program (EAP)	Up to eight visits per year at no cost to you	Not Available
Eye Exam for Nonrefractive Care due to sudden illness or injury to the eye	$15 copay if PCP; $25 if specialist	30%
Eyeglasses/Contact Lenses (initial pair only when required due to the loss of a natural lens)	15%	30%
Family Planning – physician's office – outpatient facility – inpatient facility	 $15 copay if PCP; $25 if specialist 15% 15%	 30% 30% 30%
Hearing Exam **Hearing Aid**	$15 copay if PCP; $25 specialist 15%	30% 30%
Home Health Care	15%	30%
Hospice Services	15%	30%
Infertility Treatment: – physician's office – outpatient facility – inpatient facility	 $25 copay 15% 15%	 30% 30% 30%
Injections in Physician's Office – allergy shots – immunization/ vaccine – all other injections	 15% Covered in full Office visit copay	 30% 30% 30%
Inpatient Services	15%	30%

Benefit	In-Network Option	Out-of-Network Option
IMPORTANT *For coverage detail, please refer to the information following this table.*		
Lab – Inpatient – outpatient – physician's office	 15% 15% 15%	 30% 30% 30%
Maternity – initial visit to determine pregnancy status – delivery, prenatal and postnatal care – nursery care for well-baby Newborn	 $15 copay if PCP; $25 if specialist 15% 15%	 30% 30% 30%
Medical Supplies	15%	30%
Nutritional Counseling	15%	30%
Occupational Therapy	15%	30%
Office Care/Visit – PCP – Specialist	 $15 copay per visit $25 copay per visit	 30% 30%
Organ Transplant	15%	30%
Outpatient Surgery – physician's office – outpatient facility	 $15 copay if PCP; $25 if specialist 15%	 30% 30%
Physical Therapy	15%	30%
Prescription dispensed other than at pharmacy (i.e., physicians office)	15%	30%
Preventive Care	Covered in Full	30%
Prosthetic Appliances	15%	30%
Radiology – Inpatient – outpatient – physician's office	 15% 15% 15%	 30% 30% 30%

Benefit	In-Network Option	Out-of-Network Option
IMPORTANT *For coverage detail, please refer to the information following this table.*		
Radiation Therapy – physician's office – outpatient facility – inpatient facility	 15% 15% 15%	 30% 30% 30%
Rehabilitation Services (outpatient) – cardiac rehabilitation – occupational therapy – physical therapy – pulmonary rehabilitation – speech therapy	 15% 15% 15% 15% 15% 15%	 30% 30% 30% 30% 30% 30%
Skilled Nursing Facility/Inpatient Rehabilitation Facility	15%	30%
Speech Therapy	15%	30%
Urgent Care Facilities	15%	30%

Coverage Details

The table above provides information about member's costs for ***eligible expenses*** that are covered under this Plan. The following information provides more detailed descriptions of the covered medical services provided under this Plan as well as limitations on coverage.

Acupuncture Services (Prior Authorization Required)

The Plan covers services for acupuncture services as follows:

- A maximum combined paid benefit of $1,500 for acupuncture and chiropractic services per calendar year per covered member. This maximum applies to in- and out-of-network acupuncture and chiropractic benefits combined.
- X-rays and other services provided by a licensed acupuncturist or licensed doctor of oriental medicine either in or out-of-network with no review required.

Allergy Services

The Plan covers services related to allergies as referenced in the table outlining benefits.

Ambulance Services

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

Ground Ambulance Services

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

Air Ambulance Services

- Air ambulance is covered only when ground transportation is impossible or would put life or health in serious jeopardy
- Transport by air ambulance to a facility nearest to the member's established home if his/her condition precludes his/her ability to travel by a nonmedical transport
- If the member is in line for a transplant and the transplant has been approved by CIGNA HealthCare and there are no commercial flights to the city in which the organ is available, the Plan will cover the medical transport of the patient via air ambulance or a jet (whichever is less expensive). Nonemergency services (e.g., home to ***physician*** for an office visit, etc.) are not covered.

Behavioral Health Services

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

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

The Plan allows unlimited ***outpatient*** mental health and ***substance abuse*** visits.

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

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

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

- If CIGNA Behavioral Health determines that ***partial hospitalization*** is required, then two ***partial hospitalization*** days are counted as one 24-hour hospitalization day.

The plan covers rehabilitation services at a licensed residential treatment facility as follows:

- 30 days of the 90-day-***inpatient***-day maximum are allowed per calendar year, with the exception of 60 days allowed out of the 90 days for eating disorders.
- Up to 120 days of the ***inpatient*** day maximum are allowed in any five consecutive calendar-year time frame.
- For any residential treatment stay, there must be at least six hours of therapy provided every day.

IMPORTANT

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

Guidelines

- Services are requird to be pre-authorized by CIGNA Behavioral Health if the benefit is not covered by ***Medicare*** (otherwise you incur a $300 penalty).
- Any combination of in-network and out-of-network benefits for ***inpatient*** mental health services and/or ***substance abuse*** services is limited to 90 days per calendar year.
- If there are multiple diagnoses, the Plan will only pay for treatment of the diagnoses that are identified in the current edition of the *Diagnostic and Statistical Manual* of the American Psychiatric Association (APA).

- Medical services provided such as lab or radiology are paid under the medical benefit.
- Wilderness programs, boot-camp type programs, work-camp type programs, or recreational type programs are not covered.

Biofeedback Services *(Prior Authorization Required)*

The Plan covers biofeedback services as follows:

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

Cancer Services

The Plan covers oncology services as follows:

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

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

Chiropractic Services *(Prior Authorization Required)*

The Plan covers chiropractic services as follows:

- Maximum combined paid benefit of $1,500 for acupuncture and chiropractic services per calendar year per covered member. This maximum applies to in- and out-of-network acupuncture and chiropractic benefits combined.
- X-rays and other services provided by a licensed chiropractor or licensed doctor of oriental medicine either in or out-of-network with no review required.

Dental Services *(Prior Authorization Required)*

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

- As a result of accidental ***injury*** to sound, natural teeth and the jaw

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

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

Dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not covered.

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

Diagnostic Tests

The Plan covers diagnostic tests as follows:

- Lab and radiology
- Computerized tomography (CT) scans (***prior authorization*** required)
- Position emission tomography (PET) scans (***prior authorization*** required)

- Magnetic resonance imaging (MRI) (***prior authorization*** required)
- Nuclear medicine
- Echocardiograms
- Electroencephalograms
- Other diagnostic tests

Durable Medical Equipment (DME) *(Prior Authorization Required)*

The Plan covers ***DME*** 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 ***illness***, ***injury***, or disability
- Durable enough to withstand repeated use
- Appropriate for use in the home.

Examples of ***DME*** include items such as:

- Wheelchairs
- ***Hospital*** beds
- Equipment for the treatment of chronic or acute respiratory failure or conditions
- Equipment to administer oxygen
- Oxygen
- Orthopedic shoes
  - up to two pairs of custom-made orthopedic shoes are covered per year when necessary due to ***illness*** such as diabetes, post polio, or other such conditions
- Mastectomy bras
  - up to two per calendar year will be allowed following a mastectomy.
- C-PAP machine
- Bilirubin lights

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

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

CIGNA HealthCare will decide if the equipment should be purchased or rented, and you must purchase or rent the ***DME*** from the vendor CIGNA HealthCare identifies.

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

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

Emergency Care *(Prior Authorization Required)*

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

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

- ***Emergency*** services from an in-network ***provider*** will be considered at the in-network level of benefits if it is a ***medical emergency***
- ***Emergency*** services from an out-of-network ***provider*** will be considered at the in-network level of benefits
- Nonemergency services in an in-network ***hospital emergency*** room will be covered at the applicable in-network benefit
- Nonemergency services in an out-of-network ***hospital emergency*** room will be covered at the applicable out-of-network benefit
- ***Emergency*** care outside the United States will be eligible for reimbursement at the in-network level of benefits
- ***Follow-up care*** that results from a ***medical emergency*** while on travel outside the United States will be covered at the in-network level of benefit
- ***Follow-up care*** that results from a ***medical emergency*** while on travel within the United States will be covered at the in-network level of benefits only if the place of care is not located within 30 miles of any in-network ***provider***
- If you are hospitalized in an out-of-network ***hospital***, you will be transferred to an in-network ***hospital*** when medically feasible, with any ground ambulance charges reimbursed at the in-network level of benefits. If you decline to be transferred, ***hospital*** coverage will be provided under the out-of-network benefit level.
- Expenses for healthcare services that you should have received before leaving the ***service area*** or that could have been postponed safely until your return are eligible for coverage at the out-of-network benefit level.

Employee Assistance Program *(Prior Authorization Required)*

The Plan covers up to eight visits per calendar year at no cost to the covered member when obtained in-network (***EAP*** benefits are not available on an out-of-network basis) for assessment, referral, and follow-up counseling for employees and their covered dependents experiencing impairment from personal concerns that adversely affect day-to-day activity. Those concerns include:

- Health
- Marriage
- Family
- Finances
- ***Substance abuse***
- Legal issues
- Stress

IMPORTANT

*Retirees, survivors, LTD terminees, and voluntary separation incentive program (**VSIP**) participants and their covered dependents are not eligible for **EAP** benefits.*

Eye Exam/Eyeglasses/Contact Lenses

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

Note: Refractive eye exam benefits are available for employees and their covered dependents enrolled in the Sandia Vision Care Plan.

Family Planning

The Plan covers family planning services 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 intrauterine devices, 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 the Prescription Drug Program.

Hearing Aids/Exam

The Plan will cover the initial hearing exam and the hearing aid purchase if hearing loss results from a sudden loss due to ***injury*** or ***illness***. Natural hearing loss is not covered. Refer to Preventive Care in this section for information on hearing screenings.

Home Health Care Services *(Prior Authorization Required)*

Covered healthy 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 in nature
- Provided on a part-time, intermittent schedule when skilled home health care is required

Hospice Services *(Prior Authorization Required)*

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

- Provided on an ***inpatient*** or ***outpatient*** basis
- Includes 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

Although ***prior authorization*** is not required before beginning infertility treatment, it is recommended that you request a pre-determination to ensure coverage of services. If you require ***inpatient*** services, you will need to request ***prior authorization*** before receiving that service.

Retirees, survivors, ***long-term disability terminees***, and ***VSIP*** participants are not eligible for infertility benefits.

In general, the Plan pays benefits for infertility services and associated expenses for the diagnoses 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 by the Plan. There are limitations to eligible procedures (refer to Section 7. 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 maximum such as:

- Medically necessary ultrasounds and laparoscopies
- Artificial insemination
- Gamete intrafallopian transfer (***GIFT***)
- 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. 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 maximum if received through the Prescription Drug Program.

Exception

If the prescription drug or device is provided by the ***physician*** and billed through the ***provider's*** office or facility charges, the charge will be reviewed by CIGNA HealthCare to determine eligibility for reimbursement. If categorized as infertility treatment, the charges will be applied to the $30,000 maximum. These charges may also be applied to the appropriate Plan ***deductibles*** and ***out-of-pocket maximums***. Neither the Prescription Drug Program nor this Plan covers prescriptions for donors.

Injection in Physician's Office

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

- In-network
  - Allergies – 15 percent of ***eligible expenses*** after the ***deductible*** (if applicable)
  - Immunizations/vaccines – no cost to you as outlined under the Preventive Care benefit in this section
  - All other injections (e.g., cortisone, depo-provera, etc.) - $15 if in ***PCP*** office and $25 if in a ***specialists*** office
- Out-of-network services, 30 percent of ***eligible expenses***, after the **deductible**

Inpatient Care/Services *(Prior Authorization Required)*

An ***inpatient*** stay is defined as a ***hospital*** stay of 24 hours or more. If a ***hospital*** stay is billed as ***inpatient*** with charges for room and board, it will be considered ***inpatient***. If a ***hospital*** stay is billed as ***outpatient***, no room and board charges will be considered.

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

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

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

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

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

Maternity Services

Newborn and Mother's Health Protection Act: Under federal law, mothers and their newborns who are covered under group health plans are guaranteed a stay in the ***hospital*** of not less than 48 hours following a normal delivery or not less than 96 hours following a cesarean section.

Prior authorization is required ONLY if your stay will be longer than 48 hours following a normal delivery or longer than 96 hours following a cesarean section. If ***prior authorization*** is not obtained from CIGNA HealthCare within two business days or as soon as reasonably possible, benefits will be reduced by $300.

The Plan pays for maternity services as follows:

- Initial visit to the ***physician*** to determine pregnancy status
- Prenatal and postnatal visits
- Charges related to delivery
- Charges for newborn delivery services, which are paid as follows:
  - Charges billed for well-baby care are paid under the mother's benefit, subject to her ***deductible***, if applicable, and ***out-of-pocket maximum***
  - Charges billed for the newborn under any other nonwell-baby ***ICD-9*** code are paid under the newborn and subject to the newborn's ***deductible***, if applicable, and ***out-of-pocket maximum***.

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

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

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

Benefits for birthing services rendered in the home are 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 part of the network, re-

imbursement will be paid on an out-of-network level. If you are admitted to a ***hospital***, you must notify CIGNA HealthCare within two business days or as soon as reasonably possible.

IMPORTANT

Contact the Sandia HBES at (505) 844-4237 to add your newborn ***child(ren)*** *to your health coverage within 31 calendar days of the birth to continue coverage beyond the first 31 calendar days. If the newborn* ***child(ren)*** *are not added to your health coverage within 31 calendar days, any expenses billed under the newborn* ***child(ren)*** *will not be covered.*

Medical Supplies

The Plan covers certain medical supplies, including such items as:

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

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

Nutritional Counseling

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

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

Obesity Surgery *(Prior Authorization Required)*

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

- You have a minimum Body Mass Index (BMI) of 40
- You have documentation from a ***physician*** of a diagnosis of ***morbid obesity*** for a minimum of five years
- You are over the age of 21

Office Care/Visits

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

- Consultations
- Second opinions
- Post-operative follow-up
- Services after hours and ***emergency*** office visits
- Allergy testing
- Office surgery

Note: Any anesthesia done in conjunction with surgery that is performed in a ***physician's*** office (in-network) will be reimbursed to the ***copay***. For example, if you have a surgical procedure done in a ***physician's*** office (in-network) and the ***physician*** bills for anesthesia in conjunction with that surgery, you will incur a ***copay*** for the surgery and a ***copay*** for the anesthesia. Any medical supplies used in conjunction with the surgery performed in a ***physician's*** office (in-network) will be reimbursed at 100 percent of ***eligible expenses***.

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

- Supplies dispensed by the ***provider***
- Diagnostic tests (with the exception of allergy testing)
- Laboratory services
- Radiology services
- Chemotherapy (including injections)
- Radiation therapy

Organ Transplants *(Prior Authorization Required)*

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

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

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

Outpatient Surgical Services

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

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

Benefits for the professional fees are described later in this section under Professional Fees for Surgical and Medical Services.

Physical Therapy *(Prior Authorization Required)*

Prescription Drugs *(other than those dispensed by the Prescription Drug Program)*

The Plan will cover prescription drugs under the medical plan as follows:

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

Preventive Care

The Plan will not cover all care that is preventive in nature. The Plan will pay 100 percent of the ***eligible expense*** in-network charge and 70 percent of the ***eligible expense*** charge, after the ***deductible***, if done out-of-network for routine physical exams as outlined below.

Routine Physical Exams:

Well-Baby Care (0-2 years)

- Routine physical exam (including height and weight) at birth, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 18 months, and 24 months
- Hearing exam (as needed)
- Thyroid screen (as needed)
- Serum lead screen (as needed)
- PKU screen (as needed)
- Sickle cell anemia screen (as needed)
- Hemoglobin/Hematocrit, between 9 and 12 months

Note: One routine physical/annual exam is allowed each calendar year, regardless of the date of the previous routine physical exam, and no more frequently than one per calendar year. A ***member*** is eligible for an annual routine physical exam even when the ***member*** has any type of chronic ***illness*** or condition, such as high blood pressure, diabetes, etc. Allowable exams include routine preventive physicals, including annual exams and sports physicals.

Well-Child Care (3-10 years)

- Routine annual physical exam (including height and weight)
- Hearing exam (as needed)

Well-Adolescent Care (11-18 years)

- Routine annual physical exam (including height, weight, and blood pressure)
- Chlamydia screen (annually as needed)
- Rubella screen (limited to one per lifetime)
- Sexually transmitted disease screening (as needed)

Well-Adult Care (19 years of age and older)

- Routine annual physical exam (including height, weight, and blood pressure) and one well-woman exam per calendar year
- Chlamydia screen (annually as needed)
- Rubella screen (limited to one per lifetime)
- Sexually transmitted disease screening (as needed)

Immunizations/Flu Shot Services

The Plan will pay 100 percent of the ***eligible expense*** in-network charge and 70 percent of the ***eligible expense*** charge, after the ***deductible***, if done out-of-network for flu shots, pneumococcal vaccine, and immunizations related to personal travel. If you are unable to obtain the type of immunization required at the ***physician's*** office (e.g., malaria pills) in Albuquerque, New Mexico, you can go to Concentra, 3800 Commons NE (505) 822-9480, and receive in-network benefits. If you need different types of immunizations for personal travel where at least one of these is not available at a ***physician's*** office, you may obtain all of your immunizations at Concentra. If you are located anywhere else in the United States, contact CIGNA HealthCare at 1-800-244-6224 for assistance.

Note: Immunizations for Sandia business-related travel must be given at Sandia's onsite clinic; however, if Sandia's onsite clinic refers the employee offsite for immunizations, the ***member*** will be reimbursed at 100 percent of the charge, regardless of whether the ***member*** obtains the immunizations in- or out-of-network.

IMPORTANT

*It is solely up to the **provider** as to whether it is coded as preventive or diagnostic. Neither Sandia nor CIGNA HealthCare 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**.*

Laboratory Services

The Plan will pay 100 percent of the ***eligible expense*** in-network charge and 70 percent of the ***eligible expense***, after the ***deductible***, if done out-of-network, for the following laboratory services for covered members 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, monosite, 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 estrase, red blood count, white blood count, squamos 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 post-prandial 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***, ***covered members*** are entitled to one of each of the above category once every calendar year. In order to receive the preventive care benefit, however, the laboratory service must be submitted with a preventive ***ICD-9*** code. If it is submitted with a diagnostic code other then the preventive ***ICD-9*** code, the service will be reimbursed at the applicable benefit level.

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

IMPORTANT

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

Cancer Screening Services

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

Service	Allowed Frequency	Allowable Age
Pap test	Annual	14
Prostrate antigen test	Annual	50
Mammogram*	Baseline Annual	Between ages 35-39 40
Fecal occult blood test	Annual	50
Sigmoidoscopy**	Once every five years	50
Colonoscopy**	Once every ten years	50
Barium enema**	Once every five years	50

***** High-risk women with an immediate family history (mother or sister) of breast cancer are eligible for an annual mammogram upon turning age 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 ten years, OR
- A sigmoidoscopy or colonoscopy every five years before age 50 or more frequently than stated above if you have an immediate family (mother, father, sister, brother only) history of colorectal cancer.
- A barium enema once every five years in lieu of a colonoscopy or sigmoidoscopy.

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

IMPORTANT

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

Pregnancy Related Preventive Care Services

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

- Multiple marker screening between weeks 15 and18 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 in women at risk for passing on certain chromosomal disorders
- Hemoglobiopathy screening if at risk for passing on certain blood disorders
- Screening for gestational diabetes between 24 and 28 weeks

- Screening for group B strep between 35 and 37 weeks
- Initial screening for anemia, rubella, hepatitis B, and sexually transmitted diseases.

IMPORTANT

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

Bone Density Testing

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

IMPORTANT

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

Prosthetic Devices/Appliances *(Prior Authorization Required)*

The Plan covers prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include but are not limited to:

- 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 and lymphedema sleeve/stockings. There are no limitations on the number of prosthesis and no time limitations from the date of the mastectomy.

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

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

Professional Fees for Surgical and Medical Procedures *(Prior Authorization Required)*

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

The Plan will pay the following surgical expenses:

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

Reconstructive Procedures *(Prior Authorization Required)*

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

IMPORTANT

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

Improving or restoring physiology function means that the organ or body part is made to work better. An example of a ***reconstructive procedure*** is surgery on the inside of the nose so that a person's breathing can be improved or restored. There may be times when the primary purpose of a procedure is to make a body part work better. However, in

other situations, the purpose of the same procedure is to improve the appearance of a body part. Upper eyelid surgery when done to improve vision is considered a ***reconstructive procedure***. If the primary intended purpose of the procedure is to improve appearance, the procedure is considered a ***cosmetic procedure*** and is not covered under this Plan.

Clarification and notification of the following benefits are mandated by the Women's Health Act of 1998. If a participant has had a mastectomy, she may elect to have breast reconstruction. Coverage by this Plan is provided for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Replacement of an existing breast implant is covered if the initial breast implant followed mastectomy.

Rehabilitation Services (Outpatient Therapies) *(Prior Authorization Required)*

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

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

Rehabilitation services must be provided by a licensed therapy ***provider*** and under the direction of a ***physician***. Physical, occupational, and speech therapy are subject to reimbursement with demonstrated improvement as determined by CIGNA HealthCare. 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 CIGNA HealthCare.

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

Predetermination with CIGNA HealthCare is recommended.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services *(Prior Authorization Required)*

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

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

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

Benefits are available when skilled nursing and/or ***inpatient*** rehabilitation facility services are needed on a daily basis. Benefits are also available in a ***skilled nursing facility*** or ***inpatient*** rehabilitation facility for treatment of an ***illness*** 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 ***illness***, you require:

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

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

Temporomandibular Joint (TMJ) *Syndrome (Prior Authorization Required)*

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

Travel and Lodging *(Prior Authorization Required)*

A CIGNA HealthCare Lifesource Transplant Network case manager will assist the patient and family with travel and lodging arrangements related to transplant services.

IMPORTANT

For travel and lodging services to be covered, the patient must be receiving services through the CIGNA HealthCare Lifesource Transplant Network.

The Plan covers expenses for travel, lodging, and meals for the patient (provided he/she is not covered by ***Medicare***) and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day to and/or from the site of the transplant facility for the purposes of an evaluation, the procedure, or necessary post-discharge follow-up
- ***Eligible expenses*** for lodging and meals for the patient (while not a ***hospital inpatient***) and one companion. Benefits are paid at a 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 (under the age of 18), the transportation expenses of two companions will be covered, and lodging and meal expenses will be reimbursed at a rate of up to $100 per day.

Coverage for travel and lodging expenses are only available if the recipient lives more than 50 miles from the Transplant Network facility. The CIGNA HealthCare Lifesource Transplant Network case manager will assist with travel arrangements.

A combined overall maximum benefit of $10,000 per covered patient applies for all travel, lodging, and meal expenses reimbursed under this Plan in connection with all transplant procedures during the entire period that the member is covered under this Plan.

Urgent Care

The Plan will cover ***urgent care*** as follows:

- ***Urgent care*** in an in-network ***urgent care facility*** within the United States will be reimbursed under the in-network level of benefits.
- ***Urgent care*** in an out-of-network ***urgent care facility*** within the United States will be reimbursed under the out-of-network level of benefits.
- If you are on travel 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 on travel 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 in-network level of benefit.
- ***Follow-up care*** while traveling within the United States will be covered at the in-network level of benefits only if the place of care is not located within a 30-mile radius of any in-network ***provider***.

Section 7. Exclusions

Although this CIGNA Premier PPO Plan provides benefits for a wide range of ***covered health services***, there are specific conditions or circumstances for which the Plan will not provide benefit payments. In general, the Plan will not pay for any expense that is primarily for the convenience or comfort of the covered member or his/her family, caretaker, ***physician***, or other medical ***provider***.

General Plan Exclusions

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

Exclusions	Examples
Administrative fees, penalties, and limits	Charges that exceed what CIGNA HealthCare determines are eligible expenses Insurance filing fees, attorney fees, physician charges for information released to claims administrator, and other service charges, finance or interest charges Amount you pay as a result of failure to contact CIGNA HealthCare for prior authorization/pre-certification including unauthorized care Employee Assistance Program services when you do not obtain pre-certification from CIGNA Behavioral Health Charges incurred for services rendered that are not within the scope of a provider's licensure Charges for missed appointments
Behavioral Health Services	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 learning disabilities and pervasive developmental disorders (including autism) other than diagnostic evaluation Treatment for insomnia and other sleep disorders, dementia, neurological disorders, and other disorders with a known physical basis (certain treatments may be covered under the medical portion of the Plan) Treatment that is determined by CIGNA Behavioral Health to be for the member's personal growth or enrichment

Exclusions	Examples
	Court-ordered placements when such orders are inconsistent with the recommendations for treatment of CIGNA Behavioral Health participating provider for mental health or CIGNA Behavioral Health 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 addiction (with the exception of hypnotherapy and biofeedback for tobacco addiction), withdrawal, or dependence Aversion therapies Treatment for codependency Nonabstinence-based or nutritionally based treatment for substance abuse Services, supplies, or treatments that are covered for benefits under the medical part of this Plan Treatment or consultations provided via phone. Exception: for transition of care or interim care for no more than a six-month maximum period. Services, treatments, or supplies provided as a result of any Worker's Compensation law or similar legislation, or obtained through, or required by, any government agency or program, whether federal, state, or subdivision, or caused by the conduct or omission of a third party for which the member has a claim for damages or relief, unless the member provides CIGNA Behavioral Health with a lien against such claim for damages or relief in a form and manner satisfactory to CIGNA Behavioral Health Nonorganic erectile dysfunction (psychosexual dysfunction) 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 CIGNA Behavioral Health Services or supplies that • are considered experimental or investigational drugs, devices, treatments, or procedures or • result from or relate to the application of such experimental or investigational drugs, devices, treatments, or procedures Wilderness programs, boot-camp-type programs or recreational-type programs

Exclusions	Examples
	Services or supplies that are primarily for the covered member's education, training, or development of skills needed to cope with an injury or illness Substance abuse benefits for Class II dependents
Congenital Heart Disease (CHD)	CHD services other than as listed below are excluded from coverage unless determined by CIGNA HealthCare to be proven procedures for the involved diagnoses: • Outpatient diagnostic testing • Evaluation • Surgical interventions • Interventional cardiac catheterizations (insertion of a tubular device in the heart) • Fetal echocardograms (examination, measurement, and diagnosis of the heart using ultrasound technology) and • Approved fetal interventions.
Dental procedures	Dental procedures are not covered under this Plan except for injuries to sound, natural teeth, the jawbone, or surrounding tissue, or birth defects. Treatment must be initiated within 12 months of injury. Dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not covered.
Drugs	Outpatient prescription drugs, including drugs obtained that are self-administered, are covered under the Prescription Drug Program except drugs dispensed, administered, and billed through the provider or facility that is approved by CIGNA HealthCare for coverage, and all intravenously administered medications.
Employee Assistance Program (EAP)	EAP benefits are not available to retirees, survivors, long-term disability terminees, VSIP recipients or their covered dependents
Equipment	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: • Air cleaners and/or humidifiers • Bathing apparatus • Scales or calorie counters • Blood pressure kits • Water beds Personal items, including but not limited to:

Exclusions	Examples
	• Support hose, except medically necessary surgical or compression stockings • Foam cushions • Pajamas Items payable under the Prescription Drug Program Equipment rental fees above the purchase price, with the exception of oxygen equipment
Experimental or investigative treatment	Experimental or investigative drugs, devices, medical treatments or procedures, and any related services
Hospital fees	Expenses incurred in any federal hospital, unless the covered member is legally obligated to pay Hospital room and board charges in excess of the semi-private room rate unless medically necessary and approved by CIGNA HealthCare/CIGNA Behavioral Health In-hospital personal charges (e.g., telephone, barber, TV service, toothbrushes, slippers)
Hypnotherapy	Hypnotherapy is not a covered health service with the exception that the Plan allows up to five visits, per lifetime, for smoking cessation
Infertility, Reproductive, and Family Planning	Infertility or reproduction benefits for retirees, survivors, long-term disability terminees, and VSIP recipients, and their covered dependents 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) except that charges to extract the eggs from a covered member 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 prenatal or birthing classes
Miscellaneous	Eye exams or eye refractions, except for nonrefractive care due to illness or injury to the eye Eyeglasses or contact lenses prescribed, except when required due to loss of a natural lens. Contact lenses are not considered a prosthetic device Modifications to vehicles and houses for wheelchair access Health club memberships and programs or spa treatments

Exclusions	Examples
	Treatment or services: • incurred when the patient was not covered under this Plan even if the medical condition being treated began before the date your coverage under the Plan ends • for illness or injury resulting from the covered member's intentional acts of aggression, including armed aggression, except for injuries inflicted on an innocent bystander (e.g., you did not start the act of 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 • that are reimbursable through any public program other than Medicare or through no-fault automobile insurance Charges in connection with surgical procedures for sex changes Charges for blood or blood plasma that is replaced by or for the patient Conditions resulting from insurrection, except for injuries inflicted on an innocent bystander who is a covered member under this Plan Christian Science practitioners and facilities Food of any kind unless it is the only source of nutrition, there is a diagnosis of dysphagia (difficulty swallowing), or in cases of PKU or RH factor. Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk Foods to control weight, treat obesity (including liquid diets), lower cholesterol, or control diabetes Oral vitamins and minerals (with the exception or oral calcium supplements for clinically documented hypoparathyroidism and Niferex and certain prescription vitamins) Herbs and over-the-counter medications except as specifically provided under the Plan Charges prohibited by federal anti-kickback or self-referral statutes Chelation therapy, except to treat heavy metal poisoning Diagnostic tests that are: • Delivered in other than a physician's office or health care facility • Self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests Domiciliary care 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.

Exclusions	Examples
	Physical, psychiatric or psychological exams, testing, vaccinations, immunizations, or treatments when: • Required solely for purposes of career, education, sports or camp, employment, insurance, marriage, or adoption or as a result of incarceration • Conducted for purposes of medical research • Related to judicial or administrative proceedings or order • Required to obtain or maintain a license of any type Private duty nursing received on an inpatient basis Respite care Rest cures Storage of blood, umbilical cord, or other material for use in a covered health service, except if needed for an imminent surgery.
Not a covered health service and/or not medically necessary	Treatments or services determined not to be medically necessary and not to be a covered health service by CIGNA HealthCare or CIGNA Behavioral Health.
Old claims	Claims received 12 months after the date charges were incurred.
Physical Appearance	Replacement of breast implants without documented leakage of silicon Breast reduction/augmentation except after breast cancer and/or if medically necessary Any loss, expense, or charge that results from cosmetic or reconstructive surgery, except after breast cancer. Exceptions to this exclusion include: • Repair of defects that result from surgery for which the member was paid benefits under the policy or • For the reconstructive (not cosmetic) repair of a congenital defect that materially corrects a bodily malfunction. **Note:** For the purposes of this exclusion, poor self-image or emotional or psychological distress do not constitute a bodily malfunction. Liposuction Pharmacological regimes Nutritional procedures or treatments Tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures) Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity Wigs regardless of the reason for hair loss Treatments for hair loss

Exclusions	Examples
Providers	Services: • 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 • This exclusion does not apply to mammography testing.
Services, supplies, therapy, or treatments	Charges that are: • Custodial in nature • Otherwise free of charge to the member • Furnished under an alternative medical plan provided by Sandia • For aromatherapy or rolfing (holistic tissue massage) • For developmental care after a maintenance level of care has been reached • For maintenance care • For massage therapy unless performed by a licensed chiropractor, physical therapist, or physician as a manual therapy technique for lymphatic drainage • For educational therapy when not medically necessary • For educational testing • For smoking cessation programs, except for biofeedback and hypnotherapy, which are limited to a maximum of five visits each per lifetime • For surgery and other related treatment that is intended to correct 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	• Surgical operations for the correction of morbid obesity determined by CIGNA HealthCare not to be medically necessary to preserve the life or health of the member • 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 CIGNA HealthCare/CIGNA Behavioral Health

Exclusions	Examples
Transplants	Organ and tissue transplants, including multiple transplants: • Except as identified under Organ Transplants, Section 6. Coverages and Limitations • Determined by CIGNA HealthCare not to be proven procedures for the involved diagnoses • Not consistent with the diagnosis of the condition 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) Donor costs for organ or tissue transplantation to another person unless the recipient is a covered member under this Plan.
Transportation	• Nonemergency ambulance services are not covered other than as listed in Section 6. Coverage and Limitations • Transportation except ground ambulance and air ambulance services as listed in Section 6. Coverages and Limitations
Travel	• Travel or transportation expenses, even if ordered by a physician, except as identified in Section 6. Coverages and Limitations

Section 8. Accessing Care

This section outlines how to access care through the in-network and out-of-network options, describes the difference between ***emergency*** and nonemergency and urgent and nonurgent, and explains how to access care in those situations. This section will also describe the CIGNA HealthCare and CIGNA Behavioral Health provider networks.

In-Network Option

The network available to members in this Plan is called Open Access Plus. This is a national network of ***physicians***, facilities, and suppliers who are contracted with CIGNA HealthCare and CIGNA Behavioral Health. CIGNA HealthCare negotiates discounts with their network of ***participating providers***, which results in lower out-of-pocket costs for you.

When you use the in-network option under this Plan, all services and supplies covered must be acquired from the contracted ***providers*** (in-network), be medically necessary and be an eligible covered benefit under this Plan. Refer to Section 6. Coverage and Limitations for coverage details.

CIGNA HealthCare's Open Access Plus network gives members the freedom to see any network ***specialist*** without a referral from a ***primary care physician***. Some procedures may require ***prior authorization*** or ***pre-certification***, which you are responsible for asking your ***physician*** to obtain from CIGNA HealthCare or CIGNA Behavioral Health. For the most up-to-date in-network ***provider*** listings in your area, contact CIGNA HealthCare at 1-800-244-6224 or access their website at www.mycigna.com.

The advantages of using the in-network option under this Plan include:

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

Out-of-Network Option

The out-of-network option offers a lower level of benefit, but enables the covered member to visit any licensed ***provider*** outside the Plan network for care. Out-of-pocket costs will be higher.

Members who use the out-of-network option are responsible for:

- Paying all costs up front depending on ***provider's*** payment policy
- Paying ***deductibles*** and ***coinsurance*** rate (30 percent of ***U&C*** or 50 percent for ***behavioral health*** of ***eligible expenses***) before the plan provides coverage
- Paying any amount above ***usual and customary***
- Filing all claims not filed by the ***provider***
- Obtaining ***prior authorization*** or ***pre-certification*** by calling CIGNA HealthCare for all ***hospital*** care and certain medical and ***behavioral health*** care in order to be eligible for coverage

You can access either the in-network or the out-of-network option any time you need medical care.

Out-of-Area Coverage

Under this Plan, covered members will be provided ***out-of-area coverage*** if the member resides outside of a 30-mile radius from a CIGNA HealthCare-contracted ***provider***. Those covered members will be able to go to an out-of-network ***provider***, and have their claims processed at an in-network level of coverage.

CIGNA HealthCare determines who will be placed in the out-of-area plan.

Prior Authorization

The purpose of ***prior authorization*** is that it:

- Allows you to know in advance whether a procedure, treatment, or service will be covered under your plan
- Helps ensure you receive the appropriate level of care in the appropriate setting
- Enables CIGNA HealthCare to identify situations that may allow you to receive additional attention (e.g., referrals to disease or case management programs) based on the type of service requested

To receive maximum benefits under this Plan, the ***provider*** (for in-network care) or you (for out-of-network care) must obtain ***prior authorization*** for certain benefits. It is the covered member's responsibility to check with the ***provider*** to ensure that this requirement is met. If ***prior authorization*** is not obtained when required, and this Plan is your ***primary coverage***, a $300 penalty will apply. This means that the first $300 of the claim will not be paid.

If your ***physician*** and CIGNA HealthCare do not agree in advance on the need for services or treatment, the covered member can appeal the decision by asking that CIGNA

HealthCare review the situation. Appeal procedures are listed in Section 11. Claims and Appeals. Regardless of the decision and/or recommendation of CIGNA HealthCare, or what the plan will pay, it is always up to the covered member and the doctor to decide what, if any, care he/she receives. CIGNA HealthCare does not provide medical advice.

IMPORTANT

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

Obtain ***prior authorization*** from CIGNA HealthCare by calling 1-800-244-6224.

The following services require ***prior authorization*** to receive the highest level of benefit (unless you have another plan as your ***primary coverage***):

- ***Hospital*** stay:
  - ***Inpatient*** – seven days in advance notice
  - ***Emergency*** hospitalization – call within two working days after admission, or as soon as reasonably possible
- Surgical procedures:
  - ***Inpatient*** or ***outpatient*** – seven days advance notice
  - ***Emergency*** surgery – call within two working days of procedure, or as soon as reasonably possible
- ***Outpatient pre-certification.*** The following list of services requiring ***pre-certification*** is updated from time to time. Your ***physician*** may obtain the most current list of services requiring ***pre-certification*** from CIGNA HealthCare at 1-800-244-6224
  - Acupuncture
  - Air ambulance services
  - Back/spine
  - Biofeedback
  - Carpal tunnel release
  - Cochlear implants
  - Dental service stemming from an accident or ***illness***
  - ***Durable medical equipment***
  - Endometrial ablations
  - External prosthetic appliances (some codes)
  - Home health care

- Home infusion therapy
- ***Hospice*** care
- Hysterectomy
- Infertility treatment
- Injectable medications
- Insulin pumps
- Knee arthroscopy
- MRI, CT and PET scans
- Observations stays, excluding false labor for undelivered obstetric patients
- Orthognathic procedures
- Orthotics
- Pelvic laparoscopy
- Pulmonary and cardiac rehabilitation
- Skilled nursing facility
- Speech therapy
- TMJ Temporomandibular joint syndrome procedures
- Tonsillectomy with or without adenoidectomy
- Transplantation services
- Tympanostomy tube insertion
- UPP (uvulopalatopharyngoplant) or laparoscope-aided UPP
- Varicose veins treatment

- ***Employee Assistance Program*** (except for initial visit)
- ***Behavioral Health*** – in-patient or out-patient care (except for initial visit)

IMPORTANT

The first $300 of ***covered charges*** *will not be reimbursed if you or a family* member *do not obtain required* ***prior authorization/pre-certification*** *from CIGNA HealthCare, or fail to notify CIGNA HealthCare within the required time frame for hospitalization, surgeries, and other procedures listed above. An exception to this requirement would be for a* covered member *who has primary health care coverage under another non-Sandia healthcare plan.*

Predetermination of Benefits

This Plan 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 under this Plan. Contact CIGNA HealthCare or CIGNA Behavioral Health before incurring charges that may not be covered under this Plan.

Some services may not be covered under certain circumstances (see Section 8. Exclusions) and may be limited in scope, such as acupuncture, chiropractic, speech therapy, occupational therapy, physical therapy, TMJ, infertility, and procedures that are cosmetic. Predetermination of benefits is recommended to help you determine your out-of-pocket expense. Also, some benefits require ***prior authorization*** as described above. Therefore, it is important that you call CIGNA HealthCare or CIGNA Behavioral Health at 1-800-244-6224 for information on covered services.

Case Management

The Case Management Program assists patients requiring extensive hospitalization and/or patients that have complicated discharge-planning needs. The program identifies those patients so that coordination of services and alternative (***cost effective***) care arrangements can be made. Referral to case management screening takes place when you have:

- Two or more admissions within three months for the same or a related medical condition
- Two or more ***emergency*** or ***urgent care*** visits within three months for the same or related medical condition
- A ***hospital*** stay of more than 10 days
- Over $25,000 in claims year-to-date for the same or related condition.

Case management also takes place for the following medical conditions:

- Cancer
- Cerebrovascular accident
- Chronic respiratory disease
- Congenital heart disease
- Diabetes
- Immune system deficiencies
- Infectious disease
- Ischemic heart disease
- Neonatal complications
- Neurodegenerative disorders (including multiple sclerosis, muscular dystrophy, amyotrophic lateral sclerosis)
- Organ transplant

- High risks pregnancies
- Spinal cord injuries
- Trauma

Special care arrangements, as determined by the case manager, are coordinated with the ***physician***.

Case management is a voluntary, confidential, and private process, and may involve some or all of the following activities:

- Establishing goals and care plan with the ***physician***, covered member, and/or family that may include onsite visits
- Assessing ongoing treatment at a ***hospital***, rehabilitation center, nursing home, ***hospice***, or the covered member's home
- Investigating alternative facilities and services
- Establishing home health care treatment, if appropriate
- Planning for discharge

Case management ensures that medically necessary and appropriate services are provided to the covered member. The evaluation process used in case management may reduce medically unnecessary, inappropriate, and/or harmful services, and manage costs in some cases. Call CIGNA HealthCare, 1-800-244-6224, for more information.

Disease Management (CIGNA HealthCare)

The CIGNA HealthCare disease management program is known as the Well Aware Program for Better Health®. This disease management program is a voluntary program and is provided at no extra cost to members. This program helps covered members manage the following chronic conditions:

- Asthma – aims to help members prevent or lessen the severity of attacks in a variety of ways
- Diabetes – helps members understand their condition and how it affects their overall health
- Heart disease – helps members with coronary artery disease or congestive heart failure stay attuned to their day-to-day health and become better prepared to discuss their concerns with their ***physician***
- Low-back pain – helps members lessen their symptoms and manage their condition
- Chronic-obstructive pulmonary disease – helps members improve their breathing and manage their symptoms.

The covered member will receive personalized guidance and support from an experienced registered nurse. The member will receive information about his/her condition as well as reminders about important screenings and exams.

Disease Management Clinic (Sandia-specific)

The Disease Management Clinic (DMC) is a worksite specialty clinic designed to provide an exceptional level of health care for diabetes, cholesterol, and blood pressure disorders. The Sandia Disease Management Clinic is not a CIGNA HealthCare contracted ***provider***. The DMC is Sandia's interface to workplace health care and health plan services. The DMC provides access to onsite screenings, healthcare exams, preventive health education, care management, behavioral, fitness, and nutrition services, periodic laboratory testing, immunizations, and podiatry services for diabetic foot care. The Sandia clinic's multidisciplinary team of health professionals consists of internal medicine ***physicians***, certified diabetes educators, dieticians, health educators, and exercise ***specialists***.

Employees who are at increased risk for or have a history of elevated blood pressure, cholesterol, or diabetes and who are interested in becoming involved in the Sandia DMC may call 844-***HBES*** (4237) to schedule an appointment.

Behavioral Health Program

The Behavioral Health Program and the network of ***behavioral health*** care ***specialists*** are managed by CIGNA Behavioral Health (CBH). Contact CBH at 1-800-244-6224 to determine whether your ***specialist*** is an in-network ***provider***.

Under this Plan, you must see a contracted network ***provider*** for ***inpatient*** or ***outpatient behavioral health*** care services. ***Prior authorization*** for services (except for initial visit) is required from CBH.

You must have ***prior authorization*** from CBH to access ***behavioral health*** services after the first visit. ***Prior authorization*** is not required for your first appointment. If you have scheduled a second visit, make sure your ***behavioral health*** care practitioner has called CBH for ***prior authorization*** of treatment before the second visit. You will incur a $300 penalty if ***prior authorization*** to seek services from the billing ***provider*** is not on file.

Note: For help selecting an in-network ***behavioral health specialist***, contact CIGNA Behavioral Health (CBH) at 1-800-244-6224 or access the ***behavioral health providers*** list by going to www.cignabehavioral.com.

Medical Necessity Review and ***prior authorization*** of the ***behavioral health*** treatment is required in order to qualify for the maximum available benefits under this Plan. The

Medical Necessity Review determines if the treatment plan will meet your needs and whether treatment is medically necessary under the terms of this Plan. The Medical Necessity Review is conducted by CIGNA Behavioral Health and the ***behavioral health*** care ***specialist*** you have selected.

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

- Neuropsychological testing
- Intensive ***outpatient*** stays/programs
- ***Inpatient*** hospitalization
- ***Partial hospitalization***
- Residential treatment stays/programs

IMPORTANT

Generally, the in-network facility will obtain ***pre-certification****; however, it is ultimately your responsibility to make sure CIGNA Behavioral Health (CBH) is contacted at 1-800-244-6224 to initiate the review process whether you or your covered dependent are utilizing in- or out-of-network facilities.*

Make sure the ***prior authorization/pre-certification*** *is obtained to avoid paying a $300 penalty. An exception to this requirement would be for a* covered member *who has primary health care coverage under another non-Sandia healthcare plan.*

The following chart summarizes the ***behavioral health*** benefits and limitations.

CIGNA Behavioral Health Program	
In-Network Option	**Out-of-Network Option**
• Pre-certification required from CBH for inpatient, residential, partial hospitalization, neuropsychological testing or intensive outpatient stays/programs.	• Pre-certification required from CHB for inpatient, residential, partial hospitalization, neuropsychological testing or intensive outpatient stays/programs.
• Out-of-pocket maximum is applicable.	• Out-of-pocket maximum is **not** applicable.
• Must use CHB network provider or facility.	• May use any noncontracted provider or facility.
• Plan pays 85 percent of eligible expenses (no deductible for employees and their covered dependents) for inpatient and outpatient services.	• Plan pays 50 percent of eligible expenses (after you pay the deductible) for inpatient or outpatient services.
• Unlimited outpatient visits.	• Unlimited outpatient visits.

CIGNA Behavioral Health Program	
In-Network Option	**Out-of-Network Option**
• 90 days, inpatient benefit per calendar year, including both in- and out-of-network option for mental health and substance abuse.	• 90 days, inpatient benefit per calendar year, including both in- and out-of-network option for mental health and substance abuse.

Emergency Treatment for Behavioral Health

In the case of ***inpatient*** and/or ***emergency*** services, the ***behavioral health*** care practitioner, the ***emergency*** service, a friend, or family member must notify CIGNA Behavioral Health (call 1-800-244-6224 and ask for CBH) within two working days of admission or as soon as reasonably possible. If the ***hospital*** is not in the network, in-network benefits will be paid until the patient is stabilized. Once stabilized, the patient must be moved to a network ***hospital*** to continue coverage under the in-network level of benefit.

Employee Assistance Program (EAP)

This Plan provides to covered members counseling services from an ***Employee Assistance Program*** (***EAP***) ***provider***. ***EAP*** counseling services are designed to provide assessment, referral, and follow-up to covered members experiencing some impairment from personal concerns, including health, marital, family, financial, ***substance abuse***, legal, emotional and stress, that may be adversely affecting the employee's day-to-day activity.

Accessing EAP Services

You may access off-site ***EAP*** services or may contact a Sandia ***EAP provider*** to receive ***EAP*** counseling:

- You may obtain offsite ***EAP*** counseling by contacting a designated in-network ***EAP*** affiliate as identified in your CIGNA HealthCare ***provider*** directory. If you would like help identifying an in-network ***EAP*** counselor, contact CIGNA HealthCare at 1-800-244-6224 or visit www.cignabehavioral.com. You may select ***providers*** from the drop down list for the following specialties:
  - Adoption issues
  - Alcohol/***substance abuse***
  - Anxiety issues
  - ***Child***/adolescent issues
  - Cultural issues
  - Depression issues

- Eating disorders
- Faith based counseling
- Gender/sexuality
- Grief and loss
- Health issues
- Martial/couples counseling
- Medication management

In general, any masters-level clinician may provide ***EAP*** services. You may click on any counselor's name to determine if his/her clinical practice includes ***EAP***.

- You may obtain onsite ***EAP*** counseling by contacting your Sandia ***EAP*** office. The Sandia ***EAP*** is administered by the Sandia Medical Clinic and is not a contracted ***provider*** under this Plan. For Sandia ***EAP*** services call:
  - In Albuquerque, NM (505) 845-8085
  - In Livermore, CA (925) 294-2200

  The Sandia ***EAP*** provides information regarding education and training programs at the work site that focus on personal issues such as ***substance abuse***, family and marital concerns, stress, and healthy lifestyles development. The Sandia ***EAP*** also assists employees and managers in resolving work-related issues that might affect the employee's productivity.

EAP Benefits and Prior Authorization Requirements

Your ***EAP*** benefit allows covered members up to eight visits (free of charge) a year to an offsite in-network ***EAP provider***. The in-network ***EAP*** affiliate you select is responsible for calling CIGNA HealthCare to receive authorization for additional visits beyond your initial assessment visit.

Confidentiality

EAP counseling services are confidential within the limitations imposed by state and federal law and regulations. When a covered member visits an ***EAP*** counselor for the first time, confidentiality is described in more detail.

Nonemergency or Nonurgent Care When Away from Home

If you are not experiencing an ***emergency*** or ***urgent care*** situation, call the CIGNA HealthCare at 1-800-244-6224 to obtain information on in-network ***providers*** located in the area you will be visiting.

If you access an out-of-network ***provider*** or facility for nonemergency or nonurgent care, even if there are no in-network ***providers***, your claim will be processed at the out-of-network benefit level.

CIGNA HealthCare LIFESOURCE Transplant Network

CIGNA HealthCare Lifesource is a network of participating organ and tissue transplant centers that have been evaluated for favorable rates of patient outcomes, as well as waiting periods, housing arrangements, and patient friendly environments. Participants in CIGNA HealthCare Life-source are managed by the Comprehensive Transplant Case Management Unit. This unit consists of registered nurses with clinical experience in transplant, hematology/oncology, home healthcare, dialysis, critical care, and/or community care. They are specially trained to manage complex transplant cases.

In some instances, a travel allowance is offered as a feature of the program. Please be aware that most of the travel allowance is usually considered taxable income.

Prescription Drug Program

The Prescription Drug Program available to covered members is through CIGNA HealthCare participating pharmacies for retail drugs and through CIGNA Tel-Drug for mail-order prescription drugs.

As a covered member in this Plan, you are provided a three-tiered prescription drug benefit at retail stores and an in-network benefit for mail order prescription drugs.

To view the CIGNA HealthCare Preferred Drugs list, visit www.mycigna.com or call the number on the back of your CIGNA HealthCare ***ID*** card.

Prescription drugs are covered at the ***coinsurance*** amount (with minimum and maximum charges for a 30-day prescription) for retail and at a defined ***copay*** amount (for a 90-day prescription) for mail order as shown in the following table.

These amounts are subject to change and are communicated during the Open Enrollment period Sandia holds each fall:

Tier	Prescription	In-Network	Out-of-Network
	Retail (up to 30-day supply prescription)		
1	Generic	20% of retail $6 minimum and $12 maximum	50% of retail less applicable minimum copay
2	Brand Name (preferred)	30% of retail $25 minimum and $40 maximum	50% of retail less applicable minimum copay

3	Brand Name (nonpreferred)	40% of retail $40 minimum and $60 maximum	50% of retail less applicable minimum copay
Tier	**Mail Order (up to 90-day supply prescription)**		
1	Generic	$18 copay	N/A
2	Brand Name (preferred)	$65 copay	N/A
3	Brand Name (nonpreferred)	$100 copay	N/A

To get your prescription filled

- take your prescription to any CIGNA HealthCare participating pharmacy
- present your CIGNA HealthCare ***ID*** card
- pay your ***coinsurance*** amount

Participating pharmacies include major chains as well as local drug stores. Check the ***provider*** directory at www.mycigna.com or call the number on your ID card.

Savings through Mail Order – You may want to take advantage of the savings available through mail-order prescription drugs for your maintenance drugs for conditions such as arthritis, high blood pressure, asthma, diabetes, or endrocine/metabolic conditions. An example of savings is when you order a three-month supply of generic medication for $20 instead of paying $30 at a retail store for three separate prescriptions.

To start your mail-order prescriptions, ask you ***physician*** to give you two prescriptions--one 30-day prescription and a separate prescription for the year to get your prescription through mail order. You may get a mail-order form by calling Sandia ***HBES*** at (505) 844-4237 or on the web by registering for access to www.mycigna.com.

To switch to the convenience of CIGNA Tel-Drug call 1-800-835-3784, choose option 1 and mention extension 501. Please provide your prescription medication information, as well as the prescribing doctor's name and phone number. Tel-Drug will handle your switch to mail order for you – there's no paperwork!

CIGNA HealthCare members who register for access to www.mycigna.com may order refills and access their prescription order history.

The CIGNA mail-order program is through Tel-Drug (1-800-835-3784) or www.teldrug.com or mail to: CIGNA Tel-Drug, PO Box 1019, Horsham, PA 19044-9805.

Provider Networks

Network availability depends on the ability of CIGNA HealthCare to contract with ***providers***. CIGNA HealthCare has contracted with ***providers*** across the country.

Sandia, through CIGNA HealthCare, strives to make available to the covered member quality health care service by way of the credentialing process. Even though Sandia strives to provide you with quality medical services, neither Sandia nor its plans can guarantee quality of care. Employees always have the choice of what services they receive and who provides their healthcare regardless of what the Plan covers or pays.

The network ***provider***, specialty care ***physicians***, ***hospitals***, and other health care ***providers***/facilities participating in the network are contracted by CIGNA HealthCare and CIGNA Behavioral Health.

In some cases, CIGNA HealthCare has established direct contracts with individual ***providers***. The ***participating providers*** work with CIGNA HealthCare to organize an effective and efficient health care delivery system. Outside the greater Albuquerque area, CIGNA HealthCare has contracted with ***providers*** offering in-network care.

Note: Your ***physician*** may contact CIGNA HealthCare to request membership in any of these networks.

The most current ***provider*** directory of in-network ***providers*** can be found on www.mycigna.com. Register to access this valuable tool.

Provider Directories

The CIGNA HealthCare ***provider*** directories list ***providers*** and auxiliary services available in-network. You can select your ***physician*** from family care ***providers***, internists, pediatricians, and other ***specialists*** who have contracted to participate in the CIGNA HealthCare Open Access Plus network.

Specialty care and ***hospital*** services generally are provided by the ***hospital*** with which the ***physicians*** or ***specialists*** you select are affiliated.

Provider directories will be furnished by CIGNA HealthCare or may be obtained online as described below. Directories are current as of the date they are printed. The ***provider*** networks change often. For the most current information, contact CIGNA HealthCare at 1-800-244-6224 or access the website (without registering) at www.cigna.com. Select the Open Access Plus option as the network type.

Online Directories

The most up-to-date directories are available online and are updated every two weeks. Register at www.mycigna.com to access these directories as well as your personalized medical care information. The system will know in which plan you are enrolled.

When You Schedule an Appointment

When you call the ***provider's*** office to make an appointment, identify yourself as a member of the CIGNA Premier **Error! Reference source not found.** Plan (Open Access Plus network). When you check in for your appointment, use your CIGNA HealthCare ***ID*** card to identify your plan coverage and to facilitate the processing of your claim.

Note: Failure to present your CIGNA HealthCare ***ID*** card may result in incorrect billing and claim payment delay.

Canceling Your Appointment – If you cannot keep your appointment please be courteous to other members and to your ***provider*** by calling to cancel your appointment. The time you leave open is needed by someone else to receive medical care. Any charge for missed appointments will not be covered by this Plan.

Transferring Your Medical Records – If you want medical records transferred to your ***provider's*** office, ask the ***physician*** office receptionist to transfer your records.

When You Change Your Address

When you move, please change your address in the Sandia database. Active employees may change their address through Sandia's website or their center secretary. Retirees should contact the retirement coordinator through Sandia Benefits. The Benefits office is available through the following address and/or phone number:

New Mexico
Sandia Benefits Office
Department 3332, MS 1022
P.O. Box 5800
Albuquerque, NM 87185
(505) 844-4237

California
Sandia Benefits and Health Services
Department 8527, MS 9112
P.O. Box 969
Livermore, CA 94551
(925) 294-2254

Note: You must disenroll or enroll your dependents in this plan within 31 calendar days of the effective date of change in ineligibility or eligibility for coverage under this Plan.

Section 9. Resources to Help You Stay Healthy

This section provides information and resources that are available to you as a member of the CIGNA Premier PPO Plan.

CIGNA HealthCare brings a comprehensive medical program to cover you and your family's needs. It is CIGNA HealthCare's goal to provide covered members with the information to help them manage medical conditions, and the resources and tools to help them become educated health care consumers.

Note: To get your personalized information, go online at www.mycigna.com and select Register Now! You will be asked for your date of birth, zip code, and CIGNA HealthCare member ***ID***.

www.mycigna.com

Covered members of the CIGNA Premier PPO Plan may register online at www.mycigna.com to access the following information and tools:

- **Plan benefits.** View claim status, view and print an ***EOB***, order CIGNA HealthCare ***ID*** cards or print a temporary one, locate contracted ***providers***, learn about plan benefits and features, and get answers to frequently asked questions
- **Health quotient.** Fill out a brief health risk assessment questionnaire for a personal health profile and recommendations to help enhance your health and well-being
- **Health record.** Enter medications, allergies, surgeries, immunizations, and ***emergency*** contacts in a central, secure location
- **Health tracker.** Input data such as blood pressure, blood sugar, cholesterol, height, weight, and exercise -- the program will chart your results so you can share the results with your doctor
- **Quality care tool.** Access information on how ***hospitals*** rank by number of procedures performed, patients' average length of stay, and cost
- **Locate a network *provider***. Find the most up-to-date information on contracted ***providers***, ***hospitals***, and facilities closest to home and work. The website is updated every two weeks.

CIGNA HealthCare offers the following special programs for members' health care needs:

- **CIGNA HealthCare Healthy Babies®** prenatal education program provides free educational materials about pregnancy and babies. It also provides round-the-clock access to a toll-free information line staffed by experienced registered

nurses. For high-risk pregnancies, support from a registered nurse case manager helps with special-care needs. Call CIGNA HealthCare at 1-800-244-6224 or register at www.mycigna.com for more information.

- **CIGNA HealthCare Lifesource Transplant Network℠** includes more than 50 leading transplant facilities. CIGNA HealthCare offers personalized case management and a travel allowance.

The following resources are available for CIGNA HealthCare members:

- **CIGNA HealthCare 24 Hour Health Information Line℠**. Provides assistance from a registered nurse, 24 hours a day, seven days a week. The nurse can provide detailed answers to health questions, provide helpful home care suggestions, assist in choosing the most appropriate care, and assist in locating a contracted ***provider*** if you are out of your ***service area***.

  The Health Information Line℠ also provides access to hundreds of health topics through a library of audio tapes. The programs are updated regularly and are based on current medical research and treatments. You can listen to as many programs as you like, 24 hours a day, seven days a week.

  Access the Health Information Line℠ by calling 1-800-564-9286.

- **Well-Aware Disease Management Program**. Provides assistance in managing chronic conditions. Through the Well-Aware program, members can receive support with chronic conditions such as asthma, diabetes, health disease, low-back pain, and chronic obstructive pulmonary disease. Each program is personalized and offers a wide selection of tools.

Section 10. Coordination of Benefits

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

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

Policy

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

If your other health care plan, including ***Medicare***, does not cover a health service that is covered under this Plan, this Plan will pay as primary for that ***covered health service***.

IMPORTANT

Beginning January 1 of every year, or if you are a new enrollee, CIGNA HealthCare requires an update on whether any of your covered dependents have other insurance. This information needs to be provided even if your dependents do not have other insurance. If you do not provide this information, CIGNA HealthCare will put a hold on your dependent's claims and request verification in writing from the ***primary covered member*** *for other insurance. You may update your other insurance information by going online at www.mycigna.com or by calling CIGNA HealthCare at 1-800-244-6224.*

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

Under the rules of the National Association of Insurance Commissioners (NAIC) for the ***coordination of benefits*** (***COB***), ***COB***:

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

- Follows the birthday rule

Use the table below to determine which plan pays for ***primary coverage*** and which plan pays for secondary coverage.

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

Coordination of Benefits with Medicare

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

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

If you are eligible for ***Medicare primary*** coverage and are covered under this Plan (under the continuation provisions under ***COBRA*** or end-stage renal disease), ***Medicare*** is considered your primary medical coverage.

Covered members who become eligible for ***Medicare primary*** coverage should enroll in ***Medicare*** Parts A and B. Once a covered member becomes eligible for ***Medicare primary*** coverage, Sandia will pay benefits only as secondary payer, regardless of whether the ***member*** enrolled in ***Medicare*** Parts A and B. Claims will be paid as though he/she enrolled in both ***Medicare*** Parts A and B.

IMPORTANT

If a covered member *who is eligible for* ***Medicare primary*** *coverage is provided* ***primary coverage*** *under this or any other Sandia-sponsored health plan, the* ***primary covered member*** *will be responsible for reimbursing Sandia for any ineligible benefits.*

Subrogation and Reimbursement Rights

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

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

- The Plan and/or ***claims administrator*** is subrogated to any recovery from or right of action against that third party (agree to pay Sandia back if third party pays you)
- You and/or your covered dependent will not take any action that would prejudice the Plan's ***subrogation*** rights (you will not impede the Plan's recovery actions)

- You and/or your covered dependent will cooperate in doing what is reasonably necessary to assist in any recovery, including seeking recovery of medical expenses as an element of damages in any action you bring as a result of the activity resulting in the ***illness*** or ***injury*** (you will assist the Plan to directly or indirectly recover payments)
- You and/or your covered dependent shall reimburse CIGNA HealthCare from any money recovered from the third party for any ***injury*** or treatment or condition for which CIGNA HealthCare provided benefit
- CIGNA HealthCare will recover payments only to the extent that Plan benefits paid for treatment were provided as a result of the ***injury*** or condition giving rise to the claim.

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

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

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

Section 11. Claims and Appeals

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

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

Covered member who become eligible for ***Medicare primary*** coverage should enroll in ***Medicare*** Parts A and B. Once a covered member becomes eligible for ***Medicare primary*** coverage, Sandia will pay benefits **only** as secondary payer, regardless of whether the member enrolled in ***Medicare*** Parts A and B. Claims will be paid as though the covered member enrolled in both ***Medicare*** Parts A and B.

IMPORTANT

If a covered member *who is eligible for* ***Medicare primary*** *coverage is provided* ***primary coverage*** *under this or any other Sandia-sponsored medical plan, the* ***primary covered member*** *will be responsible for reimbursing Sandia for any ineligible benefits.*

Obtaining Reimbursement

IMPORTANT

All claims must be submitted within 12 months after the date of service in order to be eligible for consideration of payment. The 12-month requirement will not apply if you are legally incapacitated. If your claim relates to an ***inpatient*** *stay, the date of service is the date your* ***inpatient*** *stay ends.*

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

To obtain reimbursement for medical care coverage under this Plan, attach the itemized medical bill to the claim form and mail it to the address shown on the claim form or to the address on the back of your CIGNA HealthCare ***ID*** card. Itemized medical bills should include:

- Patient's full name
- Data 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, a copy of the ***EOB*** (from the primary insurer) attached to your claim form

How to Submit Claim Form

You may obtain a claim form from Sandia ***HBES*** (Building 832 East) or by calling Sandia ***HBES*** at (505) 844-4237. You may also obtain a claim form from CIGNA HealthCare, 1-800-244-6224 or from the web at www.cigna.com.

The claim form should be completed only if the ***provider*** is not submitting the claim on your behalf.

If you are completing the form by hand, please use a new printed form rather than a photocopy and be sure to print clearly and use black ink when you complete the form as this ensures that the claim form can be scanned into the system. Please do not staple your bills to your claim form.

Benefits Payment

CIGNA HealthCare sends payment to the ***provider***, unless the ***provider*** is not contracted with CIGNA HealthCare and you submit a receipt that shows you paid in full (a zero balance) with your itemized bill and the claim form.

CIGNA HealthCare reserves the right to request additional documentation, such as medical records prior to processing your claim.

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

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

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

- A ***QMCSO*** that requires a health plan to provide benefits to the ***primary covered member's child***

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

CIGNA HealthCare will send the covered member an ***EOB*** statement after processing the claim. The ***EOB*** will let the covered member know if there is a balance due by the patient. If any claims are denied in whole or in part, the ***EOB*** will include the reason for the denial or partial payment. You can also view and print your ***EOBs*** online at www.mycigna.com.

IMPORTANT

All claims must be submitted within 12 months after the date of service in order to be eligible for consideration of payment. The 12-month requirement will not apply if you are legally incapacitated. If your claim relates to an ***inpatient*** *stay, the date of service is the date your* ***inpatient*** *stay ends.*

Timing of Claims Payments

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

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

Urgent Care Claims

Time Frame for Response from CIGNA HealthCare

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

Extension

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

Period for Claimant to Complete Claim

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

Other Related Notices

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

Nonurgent Pre-service Claims

Time Frame for Response from CIGNA HealthCare

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

Extension

CIGNA HealthCare may extend the original time frame by up to 15 days if necessary due to matters beyond the Plan's control. CIGNA HealthCare/CHB must notify the claimant of the extension before the initial period ends.

Period for Claimant to Complete Claim

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

Nonurgent Post-service Claims

Time Frame for Response from CIGNA HealthCare

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

Extension

CIGNA HealthCare may extend the original time frame by up to 15 days if necessary due to matters beyond the Plan's control. CIGNA HealthCare must notify the claimant of the extension before the initial period ends.

Period for Claimant to Complete Claim

If an extension in processing is required because the claimant has failed to submit sufficient information to allow determination of the claim, the claimant will be notified and given at least 45 days from receipt of the notice to provide missing information. CIGNA HealthCare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond its control.

Concurrent Care Claims

Time Frame for Response from CIGNA HealthCare

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

Contents of Notice and Response from CIGNA HealthCare

The notice will include all of the following:

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

Claims Denials and Appeal

In performing its obligation to process and adjudicate claims for plan benefits, CIGNA HealthCare is the named claims fiduciary. CIGNA HealthCare, as the claims fiduciary, has the sole authority and discretion to determine whether submitted claims are eligible for benefits and to interpret, construe, and apply the provisions of the Plan in processing and adjudicating claims, including appeals. As the claims fiduciary, determination by CIGNA HealthCare shall be conclusive and not subject to review by Sandia. Upon written request and free of charge, a participant may examine documents relevant to his/her claim and/or appeals and submit opinions and comments.

Sandia is committed to capturing, as error-free as possible, the information you provide us. CIGNA HealthCare uses this information to review and process your claims as quickly and accurately as possible.

If CIGNA HealthCare denies your (or your dependent's) claim because of eligibility, refer to Section 2. Eligibility for eligibility appeals procedures.

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

If you have a claim denied because of…	then…
coverage eligibility (except for disability determinations)	contact Sandia HBES at (505) 844-4237.
benefits administration or any other reason	contact CIGNA HealthCare at 1-800-244-6224.

IMPORTANT

A request for further information (such as a diagnosis) from the provider of service is not a claim denial. It is an ***ERISA*** *requirement to notify the* member *that processing of the claim is pending further information from the service provider. Contact CIGNA Healthcare at 1-800-244-6224 if you require further information.*

Filing an Appeal

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

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

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

For urgent claims that have been denied, you or your ***provider*** may call CIGNA HealthCare at 1-800-244-6224 to request an appeal.

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

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

Send the written appeal to:

CIGNA HealthCare
Appeals Department
700 N. Brand Blvd.
Glendale, CA 91203

Two Levels of Appeals

Two levels of appeals are permitted for each type of claim that is denied. These are described in the following steps:

Step 1: First Level of Appeal

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

Step 2: Second Level of Appeal

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

Timing of Appeals Decisions

Separate schedules apply to the timing of claims appeals, depending on the type of claim: ***urgent care***, pre-service, or post-service claims. If the claimant does not receive a written response from CIGNA HealthCare within the time periods described above, the claimant should treat the claim as denied and proceed immediately to the next level of appeal, request an external review, or seek legal recourse.

IMPORTANT

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

Urgent Care Claims

Period for Filing Appeals

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

Note: You do not need to submit ***urgent care*** claims appeals in writing. Call CIGNA HealthCare as soon as possible to appeal an ***urgent care*** claim.

Time Frame for Response from CIGNA HealthCare

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

Nonurgent Pre-service Claims

Period for Filing Appeals

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

Time Frame for Response from CIGNA HealthCare

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

Nonurgent Post-service Claims

Period for Filing Appeals

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

Time Frame for Response from CIGNA HealthCare

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

External Review

If you are not satisfied with the decision following completion of the second-level appeal process, and your claim was denied based upon lack of medical necessity or the ***experimental*** nature of the treatment, and if your claim was above $1,000, you may request that your claim be reviewed by an external independent review organization.

The independent review organization is composed of persons who are not employed by CIGNA HealthCare or CIGNA Behavioral Health or any of its affiliates. There is no charge for you to initiate this independent review process. CIGNA HealthCare will abide by the decision of the independent review. Administrative eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must write to CIGNA HealthCare at the address above within 180 days of your receipt of the second-level appeal denial. You may provide additional information to be considered. CIGNA HealthCare will acknowledge receipt of your request and will notify you when your file has been sent for external review.

The independent reviewer will render an opinion within 60 days upon receipt of all information. If you are not satisfied with the outcome of this review, you have the right to seek legal recourse.

IMPORTANT

*The **claims administrator**, CIGNA HealthCare, has the exclusive right to interpret the provisions of this Plan (with the exception of eligibility provisions), to construe its terms, to determine the amount and level of benefits payable, and to determine disability status as required for continuation as* Class I dependent *after age 24. The determination of CIGNA HealthCare is conclusive and binding.*

Other Insurance Request for Dependents

Beginning January 1 of every year, or if you are a new enrollee, CIGNA HealthCare will need an update on whether any of your covered dependents have other insurance. This information needs to be provided even if your dependents do not have other insurance. CIGNA HealthCare will pay claims and request verification from the ***primary covered member*** for other insurance. Claims will be held when a $500 threshold is met and until the information is received. You may update your other insurance information by going online at www.mycigna.com or by calling CIGNA HealthCare at 1-800-244-6224.

Recovery of Excess Payment

CIGNA HealthCare, the ***claims administrator*** has the right at any time to recover any amount paid by this Plan for ***covered charges*** in excess of the covered benefits under this Plan provisions. Payments may be recovered from ***covered members***, ***providers*** of service, and other medical care plans.

IMPORTANT

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

Section 12. When Coverage Stops

This section outlines when coverage stops for employees, retirees, and Class I and Class II dependents as well as causes for termination by CIGNA HealthCare. See Section 13. Continuation of Group Health Coverage for specific rules governing when health coverage stops and how it may be continued for the above referenced groups.

Active Employees and Retirees

Plan benefits for active employees and retirees stop on the:

- Last day of the month that the employee's ***leave of absence*** or termination of employment becomes effective, except as provided under temporary continuation of coverage under ***COBRA*** or otherwise provided by law or by the provisions of this Summary Plan Description
- Date the Plan is terminated
- Last day of the month in which any cost of the coverage is not paid when due
- Date of death
- Last day of the month before the month in which the retiree becomes eligible for ***Medicare primary*** coverage (with some exceptions). Contact Sandia ***HBES*** for more information.
- Submission of a fraudulent claim

IMPORTANT

*Health care coverage may be continued in some situations (refer to Section 13. Continuation of Group Health Coverage, for **COBRA** rules). Also, special rules apply to **leaves of absence** for family and medical care (see the Family and Medical Leave Act of 1993) and for military service (Uniformed Services Employment and Reemployment Rights Act of 1994).*

Class I and Class II Dependents

Plan benefits for dependents stop on the:

- Last day of the month in which the dependent becomes eligible for coverage as an employee under any Sandia-sponsored medical plan
- Last day of the month that any cost of coverage for dependents is not paid when due
- Date ***primary covered member's*** coverage stops
- Last day of the month in which the dependent spouse legally divorces or affects a legal separation or an annulment from the ***primary covered member***

- Last day of the month in which a dependent ***child*** marries or ceases to be eligible under the definition of dependent
- Last day of the month in which the primary covered member terminates (disenrolls) dependent coverage
- Date of death
- Submission of a fraudulent claim

Note: You must disenroll your dependents within 31 calendar days of the date your dependent becomes ineligible for coverage under this Plan.

Refer to Section 13. Continuation of Group Health Coverage to determine whether your dependent may be eligible for temporary continued coverage under ***COBRA*** and refer to the ***Pre-tax Premium Plan*** booklet for specific rules regarding dropping dependent coverage if your premiums are being taken on a pre-tax basis.

Termination for Cause

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

- Failure to pay ***copayments***/***coinsurance***
- Permitting an unauthorized person to use your CIGNA HealthCare ***ID*** card (unless you notified CIGNA HealthCare to report that your card was lost or stolen)
- Repeated failure to make or keep appointments for medical care
- Declination of Plan benefits
- Abuse of Plan coverage by providing false information on applications or forms
- Failure to follow Plan rules and regulations
- Verbal or physical threats to ***claims administrator's*** employees, ***physicians***, or network ***providers***
- Fraudulent receipt of Plan services for noncovered persons
- Failure to comply with ***subrogation*** rules

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

Certificate of Group Health Plan Coverage

Sandia complies with the requirements of the Health Insurance Portability and Accountability Act (***HIPAA***), Pub. L. 104-191, enacted on August 21, 1996. ***HIPAA*** amended the Public Health Service Act (PHS Act), the Employee Retirement Income Security Act of 1974 (***ERISA***), and the Internal Revenue Code of 1986. The amendment provided for, among other things, improved portability and continuity of health insurance coverage in the group and individual insurance markets, and group health plan coverage provided in connection with employment.

When Sandia Benefits learns of your loss of medical coverage, or the loss of coverage for your dependents, you will receive a Certificate of Group Health Plan Coverage. This certificate provides proof of your prior health care coverage for the past 18 months or less of coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the six-month period before your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy an insurance policy (for yourself or your family member) that excludes coverage for medical conditions that are present before you enroll.

You have the right to request (for up to two years following the event that caused the loss of coverage of Sandia-sponsored health coverage) a Certificate of Group Health Plan Coverage by contacting Sandia's ***HBES***.

Section 13. Continuation of Group Health Coverage

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

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

- Employees on ***leaves of absence***
- Employees who retire
- Employees who are approved for and receiving LTD through Sandia
- Surviving spouse and dependents
- ***COBRA***-eligible persons

During Leaves of Absence

If you take a ***leave of absence***, you are eligible to continue the same medical coverage you had as an active employee. You will be allowed to change your medical plan choice every year during the Open Enrollment period Sandia holds each fall.

Note: Refer to ***CPR*** 300.6.18, ***leaves of absence***, for more detail.

Sandia offers you an opportunity to continue your employer-provided medical coverage while you are on the following approved ***leaves of absence***:

- ***Child*** care – to care for a newborn ***child***, a newly adopted ***child***, or a newly placed foster ***child***
- Family care – to care for a seriously ill or injured family member
- Military Service – for service in the Uniformed Services of the United States or with the National Guard
- Tribal government appointments – to accept a Tribal government appointment (tribal governor, lieutenant governor, tribal secretary, or tribal treasurer)
- Personal – to take care of urgent personal matters
- Personal (educational) – to pursue higher education goals

- Special – to accept assignment with the government, another DOE contractor, or a college or university.

Refer to Section 4. Group Health Plan Premiums for information on the premiums for continued medical coverage under this Plan while you are on a ***leave of absence***. Contact Sandia ***HBES*** at (505) 844-4237 for more information.

IMPORTANT

*Coverage during the **leave of absence** runs concurrently with (i.e., applies toward) the temporary continued coverage under **COBRA**. If you terminate employment at the end of the leave, additional coverage months may be available under **COBRA** depending on the number of months taken for the leave. You will receive a **COBRA** notice and election at the time your leave begins (as described under **COBRA** later in this section) and you will need to submit that election in order to take advantage of continued coverage during a leave.*

Retiree Medical Plan Option

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

Upon retirement, if you are not eligible for ***Medicare primary*** coverage, the Retiree Medical Plan Option allows you to enroll in either this Plan or the CIGNA In-Network Plan. Unless you elect to enroll in your plan of choice within 31 calendar days of your retirement date, this Plan will be your primary medical coverage until you reach age 65 or you become disabled and are eligible for ***Medicare primary*** coverage through disability. You will no longer be eligible for this Plan, but you may be eligible for the CIGNA Senior Premier PPO Plan or the Lovelace Senior Plan (certain NM counties). The ***Medicare primary*** covered retiree and/or covered dependents will be defaulted into the CIGNA Senior Premier PPO if an election is not made.

All ***Medicare primary*** family members must be enrolled in the same plan, and all non-***Medicare primary*** family members must be enrolled in the same plan.

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

As an alternative to electing coverage under the Retiree Medical Plan Option, the retiree may elect to temporarily continue the same medical coverage as available to active employees by making an election under ***COBRA***. If the retiree elects ***COBRA*** coverage instead of coverage under the Retiree Medical Plan Option, the retiree cannot elect the Retiree Medical Plan Option after their ***COBRA*** coverage has terminated. If the retiree elects the Retiree Medical Plan Option, he or she must waive his/her rights to ***COBRA***.

Long-Term Disability Terminee Medical Plan Option

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

If you are under age 65 and have been receiving Social Security disability benefits for 24 months or longer or if you are age 65 or older, you are eligible for ***Medicare*** coverage. ***Medicare*** will become your ***primary coverage***. You will be eligible for either the CIGNA Senior Premier PPO Plan or Lovelace Senior Plan (certain NM counties) offered by Sandia if you enroll within 31 calendar days of becoming eligible for ***Medicare primary*** coverage. The ***Medicare primary*** disability terminee and/or covered dependents will be defaulted into the CIGNA Senior Premier PPO if a timely election is not made.

As an alternative to electing coverage under the LTD Terminee Medical Plan Option, the LTD terminee may elect to temporarily continue the same medical coverage as available to active employees by making an election under ***COBRA***. If the LTD terminee elects ***COBRA*** coverage instead of coverage under the LTD Terminee Medical Plan Option, the LTD terminee cannot elect the LTD Medical Plan Option after their ***COBRA*** coverage has terminated. If the LTD terminee elects the LTD Terminee Medical Plan Option, he/she must waive his/her rights to ***COBRA***.

Surviving Spouse Medical Plan Option

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

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

Exception

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

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

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

As an alternative to electing coverage under the Surviving Spouse Medical Plan Option, the surviving spouse and any surviving dependents may elect to temporarily continue the same medical coverage as available to active employees or non-***Medicare primary*** retirees (whichever is applicable) by making an election under ***COBRA***. If the surviving spouse elects ***COBRA*** coverage instead of coverage under the Surviving Spouse Medical Plan Option, the surviving spouse cannot elect the Surviving Spouse Medical Plan Option after their ***COBRA*** coverage has terminated. If the surviving spouse elects the Surviving Spouse Medical Plan Option, he/she must waive his/her rights to ***COBRA***.

Special Rules

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

Termination Rules

For the surviving spouse and dependents, coverage terminates if:

- The spouse marries
- The surviving spouse dies

  Note: If a surviving spouse dies, any covered dependents under the spouse may have ***COBRA*** rights.

- Payments are not received when due

Refer to Section 4. Group Health Plan Premium for premium costs for continuation of group health care coverage.

COBRA

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

COBRA ***qualified beneficiaries*** may temporarily continue coverage through Sandia by notifying Sandia of a ***qualifying event*** (other than termination, reduction of hours, or death of an employee). ***COBRA*** coverage will continue for ***qualified beneficiaries*** who pay the applicable ***COBRA*** rate, plus a two percent administrative fee, in a timely manner.

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

Covered members who become eligible for ***Medicare primary*** coverage should enroll in ***Medicare*** Parts A and B. Once a covered member becomes eligible for ***Medicare primary*** coverage, Sandia will pay benefits only as secondary payer, regardless of whether the member enrolled in ***Medicare*** Parts A and B. Claims will be paid as though the covered member is enrolled in both ***Medicare*** Parts A and B.

IMPORTANT

If a covered member *who is eligible for* ***Medicare primary*** *coverage is provided* ***primary coverage*** *under this or any other Sandia-sponsored medical plan, the* ***primary covered member*** *will be responsible for reimbursing Sandia for any ineligible benefits.*

Qualifying Events Causing Loss of Coverage

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

Qualified beneficiary if you are the…	and if you, a covered member, lose coverage under this Plan due to…	maximum period of continuation coverage is…
Employee Spouse Dependent Child	Termination of employee's employment for any reason other than gross misconduct Reduction in employee's hours of employment	18 months*
Employee Spouse Dependent Child	Termination of employment (for any reason other than gross misconduct or reduction in employee's hours of employment), and you are disabled or become disabled within the first 60 days of your COBRA coverage, as determined by Social Security and you do not have Medicare coverage.	29 months from the original COBRA qualifying event (after the first 18 months you will be charged 150% of the cost of the applicable group rate).
Spouse Dependent Child	Covered employee, retiree, or long-term disability terminee becomes entitled to Medicare Divorce or legal separation of the spouse from the covered employee, retiree, or long-term disability terminee Death of the covered employee, retiree, or long-term disability terminee	36 months
Dependent Child	Loss of dependent child status under the plan rules	36 months

*You may become entitled to an 18-month extension of your COBRA coverage (for a total maximum period of 36 months of continuation coverage) if you experience a second qualifying event such as the death of the primary qualified beneficiary, the divorce or legal separation from the primary qualified beneficiary, the primary qualified beneficiary becoming entitled to Medicare, or a loss of dependent child status under the plan.

The second event can be a second qualifying event only if it would have caused you to lose coverage under the plan in the absence of the first qualifying event. If a second qualifying event occurs, you will need to notify Sandia HBES.

Notification of Election of COBRA

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

Step	Who	Action
1	Employee or family member	Notify Sandia Benefits, in writing, within 60 days[1] after the date on which the following qualifying event: • Divorce • Legal separation • Annulment • Loss of a child's dependent status • Disability designation by Social Security Send notice to: Sandia National Laboratories Attention: Benefits Department, Mail Stop 1022 Albuquerque, NM 87185
2	Sandia Benefits	Notify Sandia Benefits COBRA administrator of covered member's qualifying event (including termination or reduction of hours of employment, death of employee, etc.
3	Sandia Benefits COBRA administrator	Notify qualified beneficiaries of their right to continue medical coverage through Sandia and how to make an election. The notice must be provided to the qualified beneficiaries within 14 days after the COBRA administrator receives the notice of a qualifying event. Contact COBRA administrator, 844-4237.
4	Qualified beneficiary	Contact the Sandia Benefits COBRA administrator to elect COBRA coverage. • Qualified beneficiary has 60 days to elect COBRA starting on the later of the date you are furnished the COBRA rights notice or the date you would lose coverage. • Qualified beneficiary must make initial premium payment within 45 days from the COBRA election date. The plan allows you a 30-day grace period for monthly premium payment thereafter. • If you elect to continue, Sandia provides coverage under the Plan at your expense plus the applicable administrative fee. • If you do not elect to continue coverage during the 60-day election period, medical coverage through Sandia ends at

[1] You must notify Sandia Benefits at (505) 844-4237 within 60 days of the date Social Security determines that you or a family member is disabled and within the first 18 months of COBRA continuation of coverage. If you fail to notify Sandia, you will lose your right to the additional COBRA coverage. If you fail to inform Sandia Benefits within 60 days of the notification date, you will no longer be eligible to participate in COBRA.

Step	Who	Action
		the end of the month in which the event occurred and the qualified beneficiary became ineligible for coverage. • Failure to make any payment within the payment date requirement described above will cause you to lose all COBRA rights. • Following the initial payment, if you do not pay a premium by the first day of a period of coverage, the plan has the option to cancel your coverage until payment is received and then reinstate the coverage retroactively back to the beginning of the period of coverage. Retroactive reinstatement is not available unless payment is received within 30 calendar days of the due date. • If the amount of payment is wrong, but is not significantly less than the amount due, the plan is required to notify you of the deficiency and grant a period of no longer than 30 days to pay the difference. The plan is not obligated to send monthly premium notices.
5	Sandia Benefits COBRA administrator	Notify qualified beneficiaries of early termination of COBRA continuation coverage if it will end prior to the maximum period that COBRA coverage is available.

Benefits under Temporary Continuation Coverage

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

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

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

Termination of Temporary Continuation Coverage

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

- Premiums are not paid in full on a timely basis
- Sandia ceases to maintain any group health plan

- A ***qualified beneficiary*** begins coverage under another group health plan after electing continuation coverage under Sandia, and that plan does not impose an exclusion or limitation affecting a pre-existing condition of the ***qualified beneficiary***
- A ***qualified beneficiary*** becomes entitled to ***Medicare*** benefits after electing continuation coverage
- A ***qualified beneficiary*** engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud)

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

Disability Extension and Multiple Qualifying Events

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

- If an individual is Social Security disabled before or during the first 60 days of an 18-month ***COBRA*** period, all of the individual's ***COBRA***-eligible family is eligible for an 11-month extension of coverage up to a maximum of 29 months from the original ***COBRA qualifying event***. After the first 18 months of ***COBRA*** coverage, he/she will be charged at 150 percent of the cost of the applicable group rate.
- The individual must provide a copy of the Social Security determination within 60 days of the date the disability determination was made and no later than 18 months after the election change event. He/she must also provide notice within 30 days of determination that the ***qualified beneficiary*** is no longer disabled.

In the event a second election change event (e.g., divorce, primary ***qualified beneficiary*** dies or becomes covered by ***Medicare***, dependent ***child*** loses dependent status) occurs during the 18-month ***COBRA*** coverage period (or during disability extension), the spouse and ***children*** already receiving continuation coverage may be eligible for additional months of coverage, up to a maximum of 36 months from the date of the original election change event. The employee must notify Sandia Benefits of the second election change event.

Section 14. CIGNA HealthCare Services

This section outlines the customer services provided by the ***claims administrator***, CIGNA HealthCare, to covered members.

Member Services

Member services are provided through the CIGNA HealthCare Member Services Unit at 1-800-244-6224, Monday through Friday, from 8:00 a.m. to 6:00 p.m. (MST). Member services include:

- Benefits information
- Claims status
- Case Management
- Disease Management
- ***ID*** cards
- ***Pre-certification***
- ***Prior authorization***
- ***Provider*** searches
- Utilization review

If you are not satisfied with the member Services Unit, a CIGNA HealthCare representative is available to assist covered members with day-to-day questions and issues, including explanation of plan provisions, access to care issues, billing issues, appeals, and referrals to case management. Call Sandia ***HBES*** at (505) 844-4237 to get in touch with a CIGNA HealthCare representative.

CIGNA HealthCare Open Access Plus ID Card

CIGNA HealthCare provides each covered member an ***ID*** card that shows Plan participation and certain coverage levels, such as ***deductibles***, ***copay*** or ***coinsurance*** percentage on the front. The back of the ***ID*** card shows the CIGNA HealthCare toll-free number for member services and the address to file claims. To facilitate efficiency of service provided and help ensure that your claims are handled properly:

- Carry your ***ID*** card with you at all times and show it whenever you access medical care.
- Show your member ***ID*** card whenever you access medical care from a:
  - ***Physician*** or ***specialist***
  - ***Hospital***

- Lab, X-ray, mammography, MRI, or other facility
- ***Emergency*** room

Hospital Admissions

Call CIGNA HealthCare at 1-800-244-6224 whenever you are hospitalized. It is your responsibility to make sure you have received the necessary authorization, called ***pre-certification,*** for your ***hospital*** stay. Call CIGNA HealthCare a minimum of five days before a scheduled admission. If you are unable to call five days in advance, you should call as soon as you know you will need ***hospital*** care. The number is on your CIGNA HealthCare ***ID*** card.

If the service is for mental health or ***substance abuse***, ask to speak with a CIGNA Behavioral Health Customer Service Representative.

CIGNA HealthCare Healthy Babies®

Call the CIGNA HealthCare number on the back of your ***ID*** card to enroll in the CIGNA HealthCare Health Babies® program.

Case Management

CIGNA HealthCare offers case management services to covered members for needs beyond a traditional ***hospital*** stay. An experienced case manager offers valuable counseling, support, and care coordination. The case manager works with you and your doctor to help sort out your options, contact facilities, arrange care, and access helpful community resources and program. The case manager can help you find ***cost effective***, quality, appropriate care for home care, ***outpatient*** treatment, or rehabilitation. Call the CIGNA HealthCare toll-free number on the back of your ***ID*** card to learn more about case management.

Emergencies

Call 911 immediately or have someone call for you. Don’t delay!

Emergencies are covered under this plan 24 hours a day, seven days a week, no matter where you are. Whenever a covered member has a serious accident or sudden ***illness***, and symptoms are severe and occur unexpectedly, seek medical help immediately.

Examples of ***emergency*** situations include:

- Uncontrolled bleeding
- Seizure or loss of consciousness

- Shortness of breath
- Chest pain or squeezing sensation in the chests
- Suspected overdose of medication or poisoning
- Sudden paralysis or slurred speech
- Severe burns
- Broken bones
- Severe pain

Call CIGNA HealthCare (1-800-244-6224) or have someone call for you within 48 hours or as soon as possible.

If you have any questions about your situation and whether it is an ***emergency***, call your personal doctor.

Urgent Care

Call your personal doctor for prompt medical attention for severe sore throat, ear or eye infection, sprains or strains, and fever. Your personal doctor may recommend steps you can take to be more comfortable and may prescribe medication if necessary. If you need to be examined, your doctor will direct you to the most appropriate type of care: ***emergency*** room, ***urgent care*** center, or office visit.

Routine Care

Routine physicals, immunizations, colds, or flu, follow-ups for injuries or broken bones, and prescription needs are all situations that should be handled through regular, scheduled office visits with your doctor.

CIGNA HealthCare 24 Hour Health Information Line℠

Health Information Library – available by phone in the U.S. anytime of day, seven days a week. Call 1-800-564-9286 to learn more about hundreds of topics such as bumps, bug bites, back pain, elder care, and cardiology. Menus guide you to the information you need.

- Programs are updated regularly and are based on current medical research and treatments.
- You can listen to as many programs as you like.
- If you'd like more information or have a question, the system will automatically connect you with a registered nurse.

Health Information Nurse Line—available any hour of the day or night for:

- Detailed answers to your specific health questions
- Helpful home care suggestions
- Help in choosing the most appropriate care – ***emergency*** room, ***urgent care***, or doctor's office visit
- Help in locating nearby ***participating providers*** when you are away from home

Prescription Drug Coverage

This Plan provides prescription drug coverage. Take the prescription from your doctor along with your CIGNA HealthCare ***ID*** card to a participating pharmacy. All you pay is the applicable ***coinsurance*** amount for covered prescriptions. Your CIGNA HealthCare ***ID*** card is accepted at more than 51,000 pharmacies nationwide, including local drug stores and national chains. Check the CIGNA HealthCare Provider Directory or visit the CIGNA HealthCare website at www.mycigna.com to find a network pharmacy.

CIGNA HealthCare Website (www.mycigna.com)

You can access your personalized information by registering at www.mycigna.com and get the most recent updated directory of ***providers***, including ***physicians***, ***specialists***, ***behavioral health***, and facilities.

If your ***provider*** is not contracted with CIGNA HealthCare, he or she can access information about becoming contracted through www.cigna.com or by calling 1-888-882-4462.

Register at www.cigna.com to access your personalized website (www.mycigna.com) information, including:

- **Plan benefits** – view claim status, order ***ID*** cards, print a temporary card, locate contracted ***providers***, learn about plan benefits and features, and get answers to frequently asked questions
- **Health quotient** – complete and print a brief, online health risk assessment and share the results with your ***provider***
- **Health tracker** – record your personal medical data
- **Quality care tool** – find information on how ***hospitals*** rank, by the number of procedures performed, patients' average length of stay, and cost

Appendix A. Acronyms and Definitions

Acronyms

COB	coordination of benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPR	Corporate Process Requirement
DME	durable medical equipment
EAP	Employee Assistance Program
EBC	Employee Benefits Committee
ERISA	Employee Retirement Income Security Act
EOB	Explanation of Benefits
FMLA	Family and Medical Leave Act
GIFT	gamete intrafallopian transfer
HIPAA	Health Insurance Portability and Accountability Act
HBES	Health, Benefits, and Employee Services
HDL	High density lipoprotein
HIV	Human Immunodeficiency Virus
ICD-9	International Classification of Diseases—the 9th edition
ID	identification
IRS	Internal Revenue Service
IRC	Internal Revenue Code
LDL	Low-density lipoprotein
LOA	leave of absence
LTD Plan	Long-Term Disability Plan
OB/GYN	obstetrical/gynecological

PCP	primary care physician
PTPP	Pre-Tax Premium Plan
QB	qualified beneficiary
QMCSO	Qualified Medical Child Support Order
RSA	Reimbursement Spending Accounts
U&C	usual and customary
VSIP	voluntary separation incentive program
ZIFT	zygote intrafallopian transfer

Definitions

allowable charges

U&C charges if the provider has a contract with CIGNA HealthCare, or the contracted fee.

alternate payee/ alternate recipient

A child or custodial parent who is not a primary covered member and who, because of a Qualified Medical Child Support Order is entitled to receive reimbursement directly from CIGNA HealthCare.

behavioral health

Mental health and/or substance abuse.

child(ren)/child

Child(ren) include:

- The primary covered member's or his/her domestic partner's own children and legally adopted children
- Adopted child (if the placement agreement and/or final adoption papers have been completed and submitted to Sandia Benefits)
- Stepchildren living with the primary covered member or his/her domestic partner (stepchildren visiting for the summer are not considered to be living with you)
- Child for whom the primary covered member or his/her domestic partner has legal guardianship
- Natural child, legally adopted child, or child for whom the primary covered member or his/her domestic partner has legal guardianship if a court decree requires you to provide coverage.

claims administrator

CIGNA HealthCare as designated by Sandia to receive, process, and pay claims according to the provisions of this Plan.

COBRA

Requires Sandia to offer a temporary extension of health care coverage to primary covered members and dependents who would otherwise lose their group health coverage as a result of certain events.

coinsurance

Cost-sharing feature by which the Plan pays a percentage of the covered charge, and the covered member pays the balance of that covered charge.

congenital anomaly

A physical developmental defect that is present at birth and is identified within the first 12 months of birth.

coordination of benefits (COB)

When a covered member has medical coverage under other group health plans (including Medicare), the Plan benefits are reduced so that the total combined payments from all plans do not exceed 100 percent of the highest allowed U&C charges or the lowest negotiated fee.

copayment/copay

A flat per-service charge you pay for services such as doctor visits. (HMOs usually have copays only.)

cost effective

Least expensive equipment that performs the necessary function. Applies to durable medical equipment and prosthetic appliances/devices.

cosmetic procedure

Procedure or service that change or improve appearance without significantly improving physiological function, as determined the by CIGNA HealthCare, the claims administrator.

covered charges

See covered health service

covered health services

Covered health services are those health services and supplies that are:

- Provided for the purpose of preventing, diagnosing, or treating illness, injury, mental illness, substance abuse or their symptoms
- Included in the Section 6.Coverages and Limitations
- Provided to a covered member who meets the Plan's eligibility requirements

custodial care

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

- A person without medical skills or background could provide or could be trained to provide
- Are provided mainly to help the covered member with daily living activities, including:
  - Walking, getting in and/or out of bed, exercising and moving the covered member
  - Bathing, using the toilet, administering enemas, dressing and assisting with any other physical or oral hygiene needs
  - Assistance with eating by utensil, tube, or gastrostomy

- Homemaking, such as preparation of meals or special diets, and house cleaning
- Acting as a companion or sitter
- Supervising the administration of medications that can usually be self-administered, including reminders of when to take such medications

- Provide a protective environment
- Are part of a maintenance treatment plan or are not part of an active treatment plan intended to or reasonably expected to improve in covered member's illness, injury, or functional ability
- Are provided for the convenience of the covered member or the caregiver or are provided because the covered member's own home arrangement are not appropriate or adequate.

deductible

The dollar amount you must pay each year before the Plan begins to pay benefits for certain covered expenses. The amount of the deductible depends on the plan you select.

developmental care

Services or supplies (regardless of where or by whom they are provided) that:

- Are provided to a member who has not previously reached the level of development expected for the member's age in the following areas of major life activity:
  - intellectual
  - physical
  - receptive and expressive language
  - learning
  - mobility
  - self-direction
  - capacity for independent living
  - economic self-sufficiency, or

- Are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to injury or illness), or
- Are educational in nature.

dual Sandian

Both spouses are employed by or retired from Sandia.

durable medical equipment (DME)

Equipment (e.g., hospital beds, wheelchairs, walkers, C-PAP machine, etc.) determined by CIGNA HealthCare to meet the following criteria:

- Is prescribed by a licensed physician
- Is medically necessary
- Is not primarily and customarily used for a non-medical purpose
- Is designed for prolonged use
- Serves a specific therapeutic purpose in treatment of an injury or illness.

Employee Assistance Program (EAP)

Short-term counseling or referral for personal or professional development for members experiencing impairment from personal concerns that adversely affects day-to-day activity including:

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

Employee Assistance Program counselor

A licensed master's or PhD-level mental health clinician who provides information, assessment, short-term counseling, and referrals.

eligible expenses

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

- In-network benefits – contracted rates with the provider
- Out-of-network benefits:

- Selected data resources which, in the judgment of the claims administrator, represent competitive fees in that geographic area or
- Negotiated rates agreed to by the out-of-network provider and either the claims administrator or one of its vendors, affiliates or subcontractors

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

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

emergency/emergencies

See medical emergency

experimental/investigational

Any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical practice in the state in which services are provided. In addition, if federal or other governmental agency approval is required for use of any items and such approval was not granted at the time services were administered, the service is experimental. To be considered standard medical practice and not experimental or investigative, treatment must meet all five of the following criteria:

- A technology must have final approval from the appropriate regulatory government bodies
- The scientific evidence as published in peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcomes
- The technology must improve the net health outcome
- The technology must be as beneficial as any established alternatives

The improvement must be attainable outside the investigational settings.

financially dependent Persons who receive more than 50% of their financial support for the calendar year from the primary covered member.

follow-up care Reexamination of or maintenance of contact with a patient at prescribed intervals following diagnosis or treatment.

Health Care Reimbursement Spending Account A flexible spending account that is pre-tax money set aside to be used to help pay for health care expenses not reimbursed or only partially reimbursed by any medical, dental, vision, or other health insurance plan. This account can be used by active employees only.

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

hospital An institution licensed as a hospital, that

- Maintains, on the premises, all facilities necessary for medical and surgical treatment
- Provides such treatment on an inpatient basis, for compensation, under the supervision of physicians
- Provides 24-hour service by registered graduate nurses
- An institution that qualifies as a hospital, a psychiatric hospital, or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals
- An institution that:
    - Specializes in treatment of mental illness, alcohol or drug abuse, or other related illness
    - Provides residential treatment programs
    - Is licensed in accordance with the laws of the appropriate legally authorized agency.

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

hospital confinement

A medically necessary hospital stay of 24 consecutive hours or more in any single or multiple departments or parts of a hospital for the purpose of receiving any type of medical service. These requirements apply even if the hospital does not charge for daily room and board. How the hospital classified the stay is irrelevant as well.

Any hospital confinement satisfying this definition will be subject to all contract provisions relating to inpatient hospital services or admissions, including any applicable preadmission review requirements. Hospital stays or services not satisfying this definition will be considered under the contract provisions for outpatient services.

illness

A disease, disorder, or condition that requires treatment by a physician. For a female member, illness includes childbirth or pregnancy. The term illness as used in this plan description does not include mental illness or substance abuse, regardless of the cause or origin of the mental illness or substance abuse.

injury

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

inpatient

A person who is formally admitted to a hospital, skilled nursing facility, or inpatient rehabilitation facility and who occupies a hospital bed, crib, or bassinet while under observation, care, diagnosis, or treatment for at least a 24-hour confinement period.

intensive outpatient services

A program that provides 9 to 20 hours per week (less than 4 hours per day) of professionally directed evaluation and/or treatment.

jaw joint disorder (TMJ)

Any misalignment, dysfunction, or other disorder of the jaw joint (or of the complex of muscles, nerves, and tissues related to that joint). It includes temporomandibular joint (TMJ) dysfunction, arthritis, or arthrosis; other craniomandibular joint disorders; and myofascial or orofacial pain syndrome. It does not include a fracture or dislocation that results from an injury.

leave of absence/ leaves of absence	An approved absence without pay of more than 30 consecutive calendar days.
living with you	A person living in your home at least 50% of the year. Stepchildren visiting for the summer are not considered to be living with you.
long-term disability terminee	An employee who has been approved for and is receiving disability benefits under Sandia's Long-Term Disability Plan or Sandia's Long-Term Disability Plus Plan.
maintenance care	Treatment beyond the point where material or significant improvement is to be expected. The treatment results in no measurable or objective improvement. For modality treatments, such as nonsurgical spinal treatment or physical therapy, the treatment provides no evidence of lasting benefit; treatment provides only relief of symptoms.
medical director	The physician designated by CIGNA HealthCare with review/consultation responsibilities for medically related functions such as quality assurance programs, utilization review of care, and appeals of denied claims.
medical emergency	An unforeseeable injury or illness that arises suddenly, and, in the judgment of a reasonable person, requires immediate medical care and treatment, generally received within 24 hours of onset to avoid jeopardy to life or health.
medically necessary	Services or supplies ordered by a physician or provided by a hospital, physician, or other provider that the medical director or designee has determined are: • Provided for the diagnosis or direct treatment of an injury or illness • Appropriate and consistent with symptoms and findings or diagnosis and treatment of an injury or illness, and not experimental or investigative • Provided in accordance with generally accepted medical practice on a national basis • Not solely for the convenience of the member, plan physicians, or other health care plan provider

- The most appropriate supply or level of service that can be provided on a cost-effective basis including, but not limited to, inpatient versus outpatient care, electric versus manual wheelchair, surgical versus medical or other types of care
- Allowable under the provisions of this Plan as prescribed by the member's physician.

IMPORTANT

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

Medicare — A federal program administered by the Social Security Administration that provides benefits partially covering the cost of necessary medical care.

Medicare eligible — The member is eligible to enroll in Medicare Parts A and B regardless of whether he or she enrolls.

Medicare primary — The member is eligible to receive Medicare benefits first before Sandia's plan is required to pay, regardless of whether the member enrolled in Medicare Parts A and B.

mid-year election change event — An event that allows primary covered members to make certain changes to their health care coverage. Refer to the Pre-Tax Premium Plan booklet.

morbid obesity — A condition in which an adult has been 100 pounds over normal weight (by CIGNA HealthCare's underwriting standards) for at least five years despite documented unsuccessful attempts to reduce under a physician-monitored diet.

negotiated fee — A contractual fee agreed to by providers (see participating providers) or facilities and CIGNA HealthCare for service provided to CIGNA HealthCare members.

nonparticipating — Licensed provider or facility not contracted with or employed by CIGNA HealthCare.

nonsurgical spinal treatment Detection or nonsurgical correction (by manual or mechanical means) of a condition of the vertebral column, including:

- Distortion
- Misalignment
- Subluxation
- to relieve the effects of nerve interference that results from or relates to such conditions of the vertebral column

out-of-area coverage Coverage provided for members whose residence is located outside a 30-mile radius of a CIGNA HealthCare-contracted provider. CIGNA HealthCare will determine who will be placed in the out-of-area plan.

out-of-pocket maximum The covered member's financial responsibility for covered medical expenses before the Plan reimburses additional covered charges at 100% for the remaining portion of that calendar year.

outpatient A person who visits a clinic, emergency room, or health facility and receives health care without being admitted as an overnight patient (under a 24-hour stay)

outpatient surgery Any invasive procedure performed in a hospital or surgical center setting when a patient is confined for a stay of less than 24 consecutive hours.

outpatient surgery facility A facility that is either free-standing or associated with a hospital or physician's office that is permanently equipped to perform surgery without requiring an overnight stay.

partial hospitalization A program that provides covered services to persons who are receiving professionally directed evaluation or treatment and who spend only part of a 24-hour period (but at least four hours per day) or 20 hours per week in a hospital or treatment center.

participating providers The health care professionals, hospitals, facilities, institutions, agencies, and practitioners contracted with CIGNA HealthCare to provide covered services and supplies to CIGNA HealthCare members.

physician

Any of the following licensed practitioners who perform a service payable under this Plan:

- A doctor of medicine (MD), osteopathy (DO), podiatry (DPM), or chiropractic (DC)
- A licensed doctoral, clinical psychologist
- A master's-level counselor and licensed or certified social worker who is acting under the supervision of a doctor of medicine or a licensed doctoral, clinical psychologist
- A licensed physician's assistant (PA)
- A licensed nurse practitioner
- Where required to cover by law, any other licensed practitioner who:
  - Is acting within the scope of his/her license
  - Performs a service that is payable under this Plan
  - A physician eligible for reimbursement by the Plan does not include a person who lives with you or is part of your family (you, your spouse, or a child, brother, sister, or parent of you or your spouse).

Plan sponsor

Sandia Corporation

post-secondary educational program

Students who are classified as Graduate, Professional Administrative or Co-op; Graduate Engineering Minorities; Undergraduate Co-op, General Clerical, Technical or Business; and General Laborer.

pre-certification

The process whereby the member calls CIGNA HealthCare to obtain prior approval for medical necessity and length of any hospital confinement.

Pre-tax Premium Plan

A Plan that allows employees to pay premiums on a pre-tax basis.

primary care physician (PCP)

The physician who coordinates and manages your total health care for routine physicals and hospitalizations, ensuring that you receive the most appropriate care for your medical needs. Your PCP may practice in family practice or internal medicine. Pediatrician and OB/GYN physicians are also considered those patients' PCP.

primary covered member The person for whom the coverage is issued; that is, the Sandia employee, retiree, survivor, or the individual who is purchasing temporary continued coverage.

primary coverage The plan that has the legal obligation to pay first when more than one health care plan is involved.

prior approval See prior authorization

prior authorization Certain services require prior authorization from the Health Services Department at CIGNA HealthCare. Prior authorization is based upon clinical findings supporting medical necessity and benefit determination. The clinical information provided to the Health Services Department aids in the medical review throughout the treatment.

provider See physician

qualified beneficiary/ qualified beneficiaries An employee, spouse, or dependent covered the day before the qualifying event, to include a child who is born to or placed for adoption with the covered member during COBRA. Qualified beneficiaries must be given the same rights as similarly situated employees, retirees, and their families.

qualifying event Under COBRA, an event that but for the COBRA requirements would result in the loss of coverage to a qualified beneficiary.

Qualified National Medical Support Notice (QNMSN) The federal government mandates that all states use this standardized form to notify an employer to withhold premiums from an employee's income when a parent is ordered to provide healthcare coverage for his/her child(ren). The QNMSN is the notice employers receive from the state child support enforcement agency instructing them to enroll a child(ren) in available dependent health coverage. The QNMSN helps ensure children receive healthcare coverage when it is available and required as part of a child support order. It is designed to simplify the work of employers and plan administrators by providing uniform documents requesting healthcare coverage.

Qualified Medical Child Support Order (QMCSO)

Upon receiving the QNMSN packet the employer determines whether the state agency has correctly completed the notice and if it meets the requirements for a Qualified Medical Child Support Order (QMCSO) under ERISA. To be qualified, a medical support order must clearly specify:

- The member's name and last-known address
- The name and address of each child covered by the order
- A reasonable description of the coverage to be provided, or the manner in which coverage will be determined
- The period for which the order applies.

If the QNMSN lacks any of the required information, but that information is reasonably available to the employer, the employer should consider the QNMSN qualified and proceed with enrolling the child(ren) in the medical plan. If the information is not available, the employer will return the QNMSN to the issuing agency.

reconstructive procedure

A procedure performed to address a physical impairment where the expected outcome is restored or improved function. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as reconstructive procedure.

service area

The geographical area, approved by the appropriate staff agency, within which participating providers are accessible to members.

short-term counseling

For Sandia's EAP, up to eight problem assessment/ counseling visits per member per calendar year. Individuals or dependents/families may access the visits separately if different problems are addressed.

skilled nursing facility

An institution or that part of an institution that provides convalescent or nursing care and is, or could be, certified as a skilled nursing care facility under Medicare.

sound natural teeth

Teeth that:

- 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

A physician who provides specialty services such as a dermatologist, podiatrist, cardiologist, etc.

subrogation

The Plan's or claims administrator's right to recover any Plan payments made because of illness or injury to you or your dependent caused by a third party's wrongful act or for negligence and for which you or your dependent have a right of action or later recovered said payments from the third party.

substance abuse

Abuse by the individual of drugs, alcohol, or other chemicals to the point of addiction, which has been diagnosed as an illness by a licensed physician.

total disability or totally disabled

Because of an injury or illness:

- You are completely and continuously unable to perform the material and substantial duties of your regular occupation and are not engaging in any work or occupation for wages or profit or

Your dependent is:

- Either physically or mentally unable to perform all of the usual duties and activities (the normal activities of a person of the same age who is in good health)
- Not engaged in any work or occupation for wages or profit.

urgent care

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

urgent care facility

Can be attached to a hospital or be free-standing, staffed by licensed physicians and nurses, and providing health care services.

urgent care services

Treatment of a sudden or severe onset of illness or injury.

usual and customary charges	Based on the range of fees charged by physicians, health care facilities, or other health care providers in the same geographical area for the same or similar services. CIGNA HealthCare has the exclusive right to determine the usual and customary charges.
utilization management/ review	A process used to review whether health care services are medically necessary and the most beneficial to your care.

IMPORTANT

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

Appendix B. Members Rights and Responsibilities

One of CIGNA HealthCare's goals is to work in cooperation with participating ***physicians*** to provide you with access to quality care and programs. The CIGNA HealthCare Quality Management Program is based on industry standards and objective measures that help CIGNA HealthCare evaluate the quality of care and services received by CIGNA HealthCare members. The program also helps CIGNA HealthCare better focus its improvement efforts. The Quality Management Program allows for input from members and ***providers*** through regular analysis.

You may contact CIGNA HealthCare, at the address or telephone number on your CIGNA HealthCare ***ID*** card, with your opinions, ideas, and thoughts. Your participation in plan surveys gives direct feedback on plan performance and policy development.

You Have a Right to:

- Medical treatment that is available when you need it and is handled in a way that respects your privacy and dignity.
- Get the information you need about your healthcare plan, including information about services that are covered, services that are not covered, and any costs that you will be responsible for paying.
- Have access to a current list of ***providers*** in the CIGNA HealthCare network and have access to information about a particular provider's education, training, and practice
- Have your medical information kept confidential by CIGNA HealthCare employees and your health care ***provider***. Confidentiality laws and professional rules of behavior allow CIGNA HealthCare to release medical information only when it is required for your care, required by law, necessary for the administration of your plan or to support CIGNA HealthCare programs or operations that evaluate quality and service. We may also summarize information in reports that do not identify you or any other participants specifically.
- Have your health care ***provider*** give you information about your medical condition and your treatment options regardless of benefit coverage or cost. You have the right to receive this information in terms you understand.
- Learn about any care you receive. You should be asked for your consent for all care, unless there is an emergency and your life and health are in serious danger.
- Refuse medical care. If you refuse medical care, your health care ***provider*** should tell you what might happen. We urge you to discuss your concerns about care with your doctor. Your doctor will give you advice, but you will always have the final decision.

- Be heard. CIGNA HealthCare's complaint-handling process is designed to hear and act on your complaint or concern about CIGNA HealthCare and/or the quality of care you receive, provide a courteous, prompt response, and guide you through CIGNA HealthCare's grievance process if you do not agree with CIGNA HealthCare's decision.
- Make recommendations regarding CIGNA HealthCare's policies on member rights and responsibilities. If you have recommendations, please contact CIGNA HealthCare's Member Services at the number on your CIGNA HealthCare ***ID*** card.

You Have the Responsibility to:

- Review and understand the information you receive about your health care plan. Call CIGNA HealthCare when you have questions or concerns.
- Understand how to use CIGNA HealthCare services.
- Show your CIGNA HealthCare ***ID*** card before you receive care.
- Schedule a new patient appointment with any new CIGNA HealthCare network ***provider***, build a comfortable relationship with your doctor, ask questions about things you don't understand, and follow your doctor's advice. You should also understand that your condition may not improve and may even get worse if you do not follow your doctor's advice.
- Understand your health condition and work with your doctor to develop treatment goals that you both agree upon to the extent that this is possible.
- Provide honest, complete information to the ***providers*** caring for you.
- Know what medicine you take, why, and how to take it.
- Pay all payments for which you are responsible, at the time service is received.
- Keep scheduled appointments and notify the doctor's office ahead of time if you are going to be late or miss an appointment.
- Pay all charges for missed appointments and for services that are not covered by your plan.
- Voice your opinions, concerns, or complaints to CIGNA HealthCare and/or your ***provider***.
- Notify Sandia Benefits, as soon as possible, about any changes in family size, address, phone number, and coverage status.

Sandia Addresses

New Mexico
Benefits Office
Department 3332, MS 1022
P.O. Box 5800
Albuquerque, NM 87185
(505) 844-4237

California
Benefits and Health Services
Department 8527, MS 9112
P.O. Box 969
Livermore, CA 94551
(925) 294-2254

Appendix C. Member Discounts

Sandia National Laboratories is providing the following information on discount programs strictly as a convenience to CIGNA HealthCare members. Sandia cannot guarantee any discounts, results, or performance for the following programs:

CIGNA HealthCare Healthy Rewards® provides discounts for members from ***participating providers***, including:

- Weight Watchers
- QuitNet® and Tobacco Solutions™ smoking cessation programs
- 10,000 Steps exercise programs
- Chiropractic care
- Magazine discounts
- Optical shop
- Eye exams, frames, and lenses
- Laser vision correction
- Hearing care
- Acupuncture
- Anti-cavity products
- Curves®

Some programs may not be available in all states. A discount program is not insurance and the member is required to pay the ***provider*** the entire amount minus the applicable discount provided through the Healthy Rewards®. You can locate ***provider*** participating in your area by logging into www.mycigna.com or by calling 1-800-870-3470.

Appendix D. Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule

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

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

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

This Plan maintains a privacy notice, which provides a complete description of your rights under ***HIPAA's*** privacy rules. Privacy notices are distributed to all new members in the ***Plan*** and are distributed to current members under a scheduled timetable regulated by ***HIPAA***. In addition, a copy of this notice is available upon request by contacting Sandia ***HBES***.

If you have questions about the privacy of your health information or you wish to file a complaint under ***HIPAA***, please contact the ***HIPAA*** officer in the Benefits Office.