SAND2012-2530P

Sandia National Laboratories

Sandia Total Health (claims administered by Kaiser Permanente Insurance Company)

(Non-Represented Employees, Pre-Medicare Retirees, Survivors, Long Term Disability Terminees)

Revised: January 1, 2012

Program Summary

Important

This Program Summary applies to non-represented employees, pre-Medicare retirees, survivors, and Long Term Disability Terminees effective January 1, 2012.

For more information on other benefit programs, refer to the *Sandia Health Benefits Plan for Employees Summary Plan Description* or the *Sandia Health Benefits Plan for Retirees Summary Plan Description.*

The Sandia Total Health Program 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 amend (in writing) any or all provisions of the Sandia Total Health Program, and to terminate (in writing) the Sandia Total Health Program at any time without prior notice, subject to applicable collective bargaining agreements.

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

National Nuclear Security Administration

Sandia National Laboratories is a multi-program laboratory managed and operated by Sandia Corporation, a wholly owned subsidiary of Lockheed Martin Corporation, for the U.S. Department of Energy's National Nuclear Security Administration under contract DE-AC04-94AL85000. SAND Number:

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Contents

Section 1. Introduction

This is a summary of highlights of the Sandia Total Health Program, a component of the Sandia Health Benefits Plan for Employees (ERISA Plan 540) and the Sandia Health Benefits Plan for Retirees (ERISA Plan 545). This Program Summary is part of the *Sandia Health Benefits Plan for Employees Summary Plan Description* or the *Sandia Health Benefits Plan for Retirees Summary Plan Description*. It contains important information about your Sandia health benefits.

Certain capitalized words in this Program Summary have special meaning. These words have been defined in the Definitions section of this Program Summary.

When the words "we", "us", and "our" are used in this document, we are referring to Sandia. When the words "you" and "your" are used throughout this document, we are referring to people who are Covered Members as defined in the Definitions section.

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

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

To receive a paper copy of this Program Summary, other Program Summaries, the *Sandia Health Benefits Plan for Employees Summary Plan Description* or the *Sandia Health Benefits Plan for Retirees Summary Plan Description*, please contact Sandia HBE Customer Service at 505-844-HBES (4237) or email hbesupport@mailca.custhelp.com. These documents are also available electronically at hbe.sandia.gov.

Since these documents will continue to be updated, we recommend that you check back on a regular basis for the most recent version.

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Section 2. Summary of Changes

The following are changes effective January 1, 2012:

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

- Employees can earn additional HRA funds through the Virgin HealthMiles program.

- Spouses and same gender domestic partners must complete a health assessment by going to healthassessment.sandia.gov in 2012 in order to earn their $250 HRA funds for 2013.

- Spouses and same gender domestic partners can earn up to an additional $250 in HRA funds through the Virgin HealthMiles program in 2012 for 2013.

- The following (Behavioral) Mental Health and Substance Abuse Service will be excluded from the plan: Treatment for learning disabilities and pervasive Developmental Disorders (including autism) other than diagnostic evaluation.

The following are clarifications to this Program Summary effective January 1, 2012:

- The Virgin HealthMiles Program is not available to retirees, survivors, or Long Term Disability Terminees.

- The Coordination of Benefits Section has been expanded to reflect policies.

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Section 3. How to Obtain Services

Welcome to Your Plan for Sandia Total Health In-Network

Network Facilities for your area are listed in greater detail in Welcome to Your Plan and www.kp.org, which describes the types of Covered Services that are available from each Network Facility in your area because some Network Facilities provide only specific types of Covered Services. It explains how to make appointments, lists hours of operation, and includes a detailed telephone directory for appointments and advice. Welcome to Your Plan provides other important information, such as preventive care guidelines. Welcome to Your Plan is subject to change and is periodically updated. You can get a copy by visiting the kp.org web site or by calling customer service.

This section describes how to access medical and behavioral health care under the In-Network and Out-of-Network options, Prior Authorization and referral requirements, predetermination of benefits, accessing non-Emergency Services or non-Urgent Care while away from home, the Kaiser Permanente Provider Network, and other general information including the Prescription Drug Program.

In-Network and Out-of-Network Options

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

Note: You can use the In-Network or Out-of-Network option at any time during the year, any time you need medical care.

The In-Network option provides you access to physicians, facilities, and suppliers who are Kaiser Permanente Network Providers. Some procedures may require Prior Authorization or a referral.

The advantages of using the In-Network option include:

- Lower Coinsurance you will pay (e.g., 20% versus 40%)
- Lower Out-of-Pocket Maximums (e.g., $2,250 versus $6,000 per person)
- No responsibility for amounts exceeding Eligible Charges
- Certain preventive care services covered at 100%
- Generally, no claims to file

The Out-of-Network option offers a lower level of benefit, but enables you to get Covered Services from licensed providers outside Kaiser Permanente's Network Provider. You are responsible for Deductibles, Coinsurance, and amounts exceeding Eligible Charges. You are also responsible for filing all claims not filed by the provider and must obtain Prior Authorization and/or referrals as required by the Program in order to be eligible for full benefits.

The following Covered Services are only available Out-of-Network but are covered under the In-Network Cost Share:

- Certain Dental Services
- Orthopedic shoes
- Infertility
  - Purchase of Eggs and Sperm
  - 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
- Maternity
  - Birthing services rendered in the home
- Reversal of Prior Sterilizations

If you are admitted to a hospital for an Emergency Medical Condition that is not In-Network and Services are covered, In-Network benefits will be paid until you are Stabilized. Once Stabilized, you must be moved to a Network Hospital to continue In-Network benefits. You may elect to remain in the Out-of-Network hospital and receive Out-of-Network benefits, as long as your Network Physician determines the treatment to be Medically Necessary.

Prior Authorization and Referral Requirements for Covered Services

IMPORTANT: Just because a Service or procedure does not require Prior Notification does not mean that it is a Covered Service.

Referrals for the Sandia Total Health In-Network Plan level

You are required to obtain a referral from your Network Physician prior to receiving certain specialty care services under the In-Network Plan level. If you receive certain specialty care services for which you did not obtain a referral, you will be responsible for all the charges associated with those services.

Self Referrals

You do not need a referral or prior authorization to receive care from any of the following:

- Your personal Network Physician
- Specialists in optometry, psychiatry, chemical dependency
- Generalists in internal medicine, pediatrics, and family practice

- Female Members do not need a referral or prior authorization in order to obtain access to obstetrical or gynecological care from a Network Provider who specializes in obstetrics or gynecology
- Out-of-Network Covered Services

Prior Authorizations for the Sandia Total Health In-Network Plan option

Certain Services require Prior Authorization in order for the In-Network Plan level to cover them. The Services that require Prior Authorization differ by Kaiser Permanente Region and are listed by Region in the "Services that Require Prior Authorization section. Your Network Physician will request Prior Authorization when it is required, except that you must request Prior Authorization in order to receive covered Post-Stabilization Care from Non-Network Providers, as described in the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers" section to be covered at the In-Network level.

Routine Care

Routine appointments are for medical needs that are not urgent, such as routine preventive care. Try to make your routine care appointments as far in advance as possible.

Urgent Care

You may need Urgent Care if you have an illness or injury that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the Urgent Care or advice nurse telephone number at 800-663-1771. Note: Urgent Care received from a Non-Network emergency department is covered under the Sandia Total Health Out- of-Network Plan level.

For information about Urgent Care outside the Service Area, please refer to the Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers section.

Advice Nurses

Sometimes it is difficult to know what type of care you need. That is why Kaiser Permanente has telephone advice nurses available to assist you. These advice nurses can help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern, tell you what to do if a Network Provider is closed, or advise you about what to do next, including making a same-day appointment for you if it is medically appropriate. To reach an advice nurse, please call the advice nurse phone number listed in the Customer Service Phone Numbers section.

Your Personal Physician

Personal physicians provide Primary Care and play an important role in coordinating care, including hospital stays and referrals to specialists. For the current list of physicians who are available as personal Network Physicians, and to find out how to select a personal Network Physician, please call customer service at the number listed in the "Customer Service Phone Numbers" section. You can change your personal physician for any reason.

Second Opinions

Upon request and subject to payment of any applicable Coinsurance, you may obtain a second opinion from:

- A Network Physician about any proposed Covered Services or
- A Non-Network Provider

Your Identification Card

Your Kaiser Permanente identification card (ID card) has a medical or health record number on it, which you will need when you call for advice, make an appointment with a Network Provider, or go to a provider for Covered Services. When you get care, please bring your Kaiser Permanente ID card and a photo ID. Your medical or health record number is used to identify your medical records and coverage information. If you need to replace your Kaiser Permanente ID card, please call customer service at the number listed in the Customer Service Phone Numbers section.

Your ID card is for identification only. In order for the Program to cover Services, you must be a current Member or Dependent on the date you receive the Services. Anyone who is not a Member or Dependent will be billed for any Services he or she receives, and the amount billed may be different from the Eligible Charges for the Services.

Receiving Care in Other Kaiser Permanente Regions

You will probably receive most Covered Services in the Service Area of the Kaiser Permanente Region where you live or work. If you are in the Service Area of another Kaiser Permanente Region, you may receive Covered Services from Network Providers in that Region, though Services that require a referral or Prior Authorization may differ among Regions. For information about Network Providers or Covered Services in another Region, please call customer service for that Region at the number listed in the Customer Service Phone Numbers section.

Getting Assistance for Sandia Total Health (In-Network)

Kaiser Permanente wants you to be satisfied with the health care you receive. If you have any questions or concerns about the care you are receiving from a Network Facility, please discuss them with your personal Network Physician or with any other Network Providers who are treating you. They want to help you with your questions. You may also call customer service at the number listed in the Customer Service Phone Numbers section.

Interpreter services for Sandia Total Health (In-Network)

If you need interpreter services when you call or when you get Covered Services, please let Kaiser Permanente know. Interpreter services are available 24 hours a day, seven days a week, at no cost to you, at Network Facilities. For more information, please call customer service at the number listed in the Customer Service Phone Numbers section.

In-Network Facilities

At most Network Facilities, you can usually receive all the Covered Services you need, including specialty care, pharmacy, and lab work. You are not restricted to a particular Network Facility, and you are encouraged to use the Network Facility that will be most convenient for you:

- All Network Hospitals provide inpatient Services and are open 24 hours a day, seven days a week
- Emergency Services are available from Network Hospital Emergency Departments as described in Welcome to Your Plan (please refer to Welcome to Your Plan or www.kp.org for Emergency Department locations in your area)
- Same day appointments are available at many locations (please refer to Welcome to Your Plan or www.kp.org for Urgent Care locations in your area)
- Many Network Facilities have evening and weekend appointments
- Many Network Facilities have a customer services department (refer to Welcome to Your Plan or www.kp.org for locations in your area)

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

This section summarizes the annual Deductibles and Out-of-Pocket Maximums that apply to the In-Network option and the Out-of-Network option, as well as any lifetime maximums under the Sandia Total Health Program.

> **Note:** If you do not have access to Network Providers within a Kaiser Permanente Service Area you will be covered under the In-Network level if you receive a referral to a provider outside the network. You can obtain services Out-of-Network without a referral but you will be required to pay a greater amount out of pocket.

Deductibles

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

If you retire and are pre-Medicare, and retire mid-year, any amounts applied towards your deductibles under your employee coverage will transfer to your retiree coverage. If you retire and are pre-Medicare, and retire mid-year, any amounts applied toward your deductibles under your employee coverage will transfer to your pre-Medicare retiree coverage.

If you change medical plans mid-year (e.g. you move from the UHC Sandia Total Health to Kaiser Permanente Sandia Total Health), any amounts applied toward your deductible under the UHC STH program will be applied to the Kaiser Permanente STH program; however, it is the employee's responsibility to obtain all of your deductible amounts/EOBs from the former administrator, UHC, and to inform the new administrator, Kaiser Permanente, where you and your dependents stand with your deductibles.

If you are dual Sandians and you switch coverage mid-year due to a mid-year qualifying event, any amounts applied toward deductibles will transfer (e.g. you marry another Sandian and you change your coverage to be enrolled under your spouse, any amounts applied towards your deductible, as a Primary Covered Member, will be applied towards your dependent deductible under this Program). It is the employee's responsibility to obtain all deductible amounts/EOBs from the former administrator, UHC, and to inform the new administrator, Kaiser Permanente, where you and your dependents stand with your deductibles.

Amounts above Eligible Charges, charges not covered by the Sandia Total Health Program, prescription drug Coinsurance and charges incurred because of failure to obtain required Prior Authorization do not apply toward the Deductible.

	In-Network Option			Out-of-Network Option		
Annual Deductible	Primary Covered Member Only	Primary Covered Member + Spouse or + Child(ren)*	Primary Covered Member + Spouse + Child(ren)* (also referred to as family)	Primary Covered Member Only	Primary Covered Member + Spouse or + Child(ren)*	Primary Covered Member + Spouse + Child(ren)* (also referred to as family)
	$750	$1,500	$2,250	$2,000	$4,000	$6,000

* Spouse or same-gender domestic partner/child(ren) for employees

IMPORTANT: The Deductibles do not cross apply between In-Network and Out-of-Network.

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

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

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

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

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

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

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

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

Deductibles for Admissions Spanning Two Calendar Years

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

Coinsurance

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

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

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

Some services require Preauthorization, otherwise you will receive reduced benefits or, in certain cases, no benefits. For a complete listing of these services, refer to Section 3, Accessing Care.

Out-of-Pocket Maximums

This section describes your Out-of-Pocket Maximums.

Note: Out-of-Pocket Maximums are not prorated for mid-year enrollments.

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

If you change medical plans mid-year (e.g. you move from the UHC Sandia Total Health to Kaiser Permanente Sandia Total Health), any amounts applied towards your out-of-pocket maximum under the UHC STH program will be applied under Kaiser Permanente Sandia Total Health; however, it is the employee's responsibility to obtain all of your out-of-pocket maximum amounts/EOBs from the former administrator, UHC, and to inform the new administrator, Kaiser Permanente, where you and your dependents stand with your out-of-pocket maximums.

If you are dual Sandians and you switch coverages mid-year due to a mid-year qualifying event, any amounts applied towards out-of-pocket maximums will transfer (e.g. you marry another Sandian and you change your coverage to be enrolled under your spouse, any amounts applied towards your out-of-pocket maximum, as a Primary Covered Member, will be applied towards your dependent deductible under this Program). It is the employee's responsibility to obtain all out-of-pocket maximum amounts/EOBs from the former administrator, UHC, and to inform the new administrator, Kaiser Permanente, where you and your dependents stand with your out-of-pocket maximums.

Medical Expenses Incurred through Kaiser (the medical claims administrator)

	In-Network Option			Out-of-Network Option		
Annual Out-of-Pocket Maximum	Primary Covered Member Only	Primary Covered Member + Spouse or + Child(ren)*	Primary Covered Member + Spouse + Child(ren)* (also referred to as family)	Primary Covered Member Only	Primary Covered Member + Spouse or + Child(ren)*	Primary Covered Member + Spouse + Child(ren)* (also referred to as family)
	$2,250	$4,500	$6,750	$6,000	$12,000	$18,000

* Spouse or same-gender domestic partner/child(ren) for employees

Note: The annual out-of-pocket maximum includes the deductible.

IMPORTANT: The Out-of-Pocket Maximums do not cross apply between In-Network and Out-of-Network.

With some exceptions (outlined in the table on page 16), no additional Coinsurance will be required for the remainder of the calendar year after you reach the applicable annual out-of-pocket Eligible Charges:

- For you: when you use the In-Network option and incur your In-Network Out-of-Pocket Maximum for covered medical expenses
- For you (and your spouse or same gender domestic partner); or you (and your child(ren) or same gender domestic partner child(ren): when you (and your spouse or same gender domestic partner); or you (and your child(ren) or same gender domestic partner child(ren) uses the In-Network option and incurs the In-Network Out-of-Pocket Maximum for covered medical expenses
- For the family: when your family uses the In-Network option and incurs the In-Network Out-of-Pocket Maximum for covered medical expenses
- For you: when you use the Out-of-Network option and incur your Out-of-Network Out-of-Pocket Maximum for covered medical expenses
- For you (and your spouse or same gender domestic partner); or you (and your child(ren) or same gender domestic partner child(ren): when you (and your spouse or same gender domestic partner); or you (and your child(ren) or same gender domestic partner child(ren) uses the Out-of-Network option and incurs the Out-of-Network Out-of-Pocket Maximum for covered medical expenses
- For the family: when your family uses the Out-of-Network option and incurs the Out-of-Network Out-of-Pocket Maximum for covered medical expenses

Example: In a calendar year, an employee family of four meets the In-Network family $6,750 Out-of-Pocket Maximum as follows:

In-Network Out-of-Pocket Maximum Example			
	Out-of-Pocket Expenses In-Network	**Applied to Out-of-Pocket In-Network**	**Applied to Out-of-Pocket Out-of-Network**
Employee	$2,250	$2,250	$0
Spouse	$2,250	$2,250	$0
1st Child	$2,250	$2,250	$0
2nd Child	$0	$0	$0
Total:	**$6,750**	**$6,750**	**$0**

The In-Network out-of-pocket maximum of $6,750 for the family has been met. For the remainder of the calendar year, any additional covered medical expenses submitted by this family under the In-Network option will be paid at 100 percent of Eligible Charges (except for prescription drugs). If any member of this family, however, seeks Out-of-Network care, the In-Network Out-of-Pocket Maximums will not apply.

Example: In a calendar year, a retiree and his spouse meet the In-Network $4,500 Out-of-Pocket Maximum as follows:

In-Network Out-of-Pocket Maximum Example			
	Out-of-Pocket Expenses In-Network	**Applied to Out-of-Pocket In-Network**	**Applied to Out-of-Pocket Out-of-Network**
Retiree	$3,500	$2,250	$0
Spouse	$10,000	$2,250	$0
Total:	**$13,500**	**$4,500**	**$0**

The In-Network Out-of-Pocket Maximum of $4,500 for the retiree plus spouse has been met. For the remainder of the calendar year, any additional covered medical expenses submitted by under the In-Network option will be paid at 100 percent of Eligible Charges (except for prescription drugs). If the retiree or spouse, however, seeks Out-of-Network care, the In-Network Out-of-Pocket Maximums will not apply.

The following table identifies what does and does not apply toward In-Network and Out-of-Network Out-of-Pocket Maximums:

Features	Applies to the In-Network, Out-of-Pocket Maximum?	Applies to the Out-of-Network, Out-of-Pocket Maximum?
Payments toward the annual Deductible	Yes	Yes
Member Coinsurance payments	Yes	Yes
Charges for non- Services	No	No
Amounts of any reductions in benefits you incur by not following Prior Notification or Precertification requirements	No	No
Amounts you pay toward behavioral health services	Yes	Yes
Charges that exceed Eligible Charges	Not applicable	No
Prescription drugs obtained through Kaiser Permanente	No	No

Prescription Drug Expenses

	In-Network Option	Out-of-Network Option
Annual Out-of-Pocket Maximum	$1,500 per person	None

IMPORTANT: The Out-of-Pocket Maximums do not cross apply between In-Network and Out-of-Network.

No additional Coinsurance will be required for the remainder of the calendar year for Covered In-Network prescription drug purchases once a covered member has met his/her $1,500 out-of-pocket maximum for the year.

Lifetime Maximums

The Sandia Total Health Program does not have any lifetime maximums, with the exception of the infertility benefit as described in the Sandia Health Benefits Plan for Employees Summary Plan Description.

When you reach the $30,000 lifetime maximum benefit, no additional reimbursement for any procedures incurred to treat infertility are payable. Other covered procedures related to family planning or reproduction (excluding infertility) may be payable.

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Section 5. Benefits and Cost Sharing

The only Services that are covered under this Program are those that this "Benefits and Cost Sharing" section says are covered, subject to exclusions and limitations described in this "Benefits and Cost Sharing" section and to all provisions in the General Exclusions, General Limitations, Coordination of Benefits, and Reductions section. Exclusions and limitations that apply only to a particular benefit are described in this "Benefits and Cost Sharing" section. Exclusions, limitations, coordination of benefits, and reductions that apply to all benefits are described in the General Exclusions, General Limitations, Coordination of Benefits, and Reductions section.

The Services described in this "Benefits and Cost Sharing" section are covered only if all the following conditions are satisfied:

- You are a Member or Dependent on the date that you receive the Services,
- A Network Physician or an Out-of-Network Provider determines that the Services are Medically Necessary,
- The Services are provided, prescribed, authorized, or directed by a Network Physician or an Out-of-Network Provider except where specifically noted to the contrary in the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers" section or the "How to Obtain Services" section,
- You receive the Services from Network Providers inside the Service Area or an Out-of-Network Provider except where specifically noted to the contrary in the following sections for the following Services:
    - Authorized referrals as described under "Referrals" and "Self Referrals" in the "How to Obtain Services" section
    - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers" section.
    - Care received outside the Service Area as described in the "Receiving Care in the Other Kaiser Permanente Regions section.
    - Emergency ambulance Service as described under "Ambulance Services" in this section.

Annual Deductible

You must satisfy an Annual Deductible. The single Annual Deductible applies separately to each person in the Family and will be due until each person either satisfies their single Deductible or the total payments by the members of the Family applied to their single Deductible reaches the family Deductible amount. Once you satisfy the single or family Annual Deductible you pay the Cost Sharing Coinsurance.

Cost Sharing Coinsurance

Cost Sharing is due at the time you receive the Services, unless your provider agrees to bill you. For items ordered in advance, you pay the Cost Sharing in effect on the order date (although the item will not be covered unless you still have coverage for it on the date you receive it). Unless specified otherwise, when services can be provided in different settings, the cost sharing is applied according to the place of service in which the care is delivered and according to the type of provider providing the service. For example: if the service is provided during a hospital admission, the Hospital Inpatient Services Cost Share is applied. If the same service is performed in an office setting by a specialist, the specialty care office visit cost share is applied.

Annual Out-Of-Pocket Maximums

There are limits to the total amount of Cost Sharing you must pay in a calendar year for certain Covered Services that you receive in the same calendar year.

If you are part of a Family that includes at least two people (counting the Member and any Dependents), you reach the annual out-of-pocket maximum when you meet the maximum per Member or Dependent, or when your Family meets the maximum for a Family (whichever happens first).

After you reach the annual out-of-pocket maximum, you do not have to pay any more Cost Sharing for Service subject to the annual out-of-pocket maximum through the end of the calendar year. You will continue to pay Cost Sharing for Covered Services that do not apply to the annual out-of-pocket maximum.

Section 6. Health Reimbursement Account (HRA)

Health Reimbursement Account Administrator

PayFlex Systems USA will administer the HRA. All of your PayFlex services will be delivered through HealthHub™ at www.HealthHub.com. PayFlex customer service can be reached at 800-284-4885.

Health Reimbursement Account (HRA) Amounts

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

- Your enrollment status (single, family, etc.),
- Whether or not you and your covered spouse/same-gender domestic partner (beginning for 2013) have completed a Health Assessment, and
- Whether or not you and your covered spouse/same-gender domestic partner (beginning for 2013) have participated in the Virgin HealthMiles Program.

Note: Retirees, surviving spouses/dependents, Long Term Disability Terminees, and COBRA participants are not required to complete a Health Assessment to receive the full HRA allocations.

2012 HRA Allocations

Only the active employee, Primary Covered Member, is responsible for completing the Health Assessment in 2011 to receive the full HRA contribution in 2012. Covered family members are not required to complete a health assessment (refer to table on next page for requirements in 2013).

Coverage Category / Tier	Health Assessment is taken	Health Assessment is NOT taken	Virgin HealthMiles activity completion	Total Possible HRA allocation[2]
Primary Covered Member only	$250	$0	$250	$500
Primary Covered Member + spouse[1]	$500	$250	$250	$750
Primary Covered Member + children[1]	$500	$250	$250	$750
Primary Covered Member + spouse and children[1]	$750	$500	$250	$1,000

[1] Includes same gender domestic partner and same-gender domestic partner child(ren) for employees.

[2] This is the only amount that will be placed in your HRA during the calendar year and may be used for any combination of eligible in-network and out-of-network Covered Services.

2013 HRA Allocations

Both the active employee (Primary Covered Member) and spouse/same-gender domestic partner are responsible for completing the Health Assessment in 2012 to receive the full HRA contribution in 2013. The spouse/same-gender domestic partner is also eligible to participate in the Virgin HealthMiles Program in 2012 to earn additional HRA funds for 2013.

Coverage Category / Tier	Health Assessment is taken	Health Assessment is NOT taken	Virgin HealthMiles activity completion	Total Possible HRA allocation[2]
Primary Covered Member only	$250	$0 (employee does not complete)	$250	$500
Primary Covered Member + spouse[1]	$500 (both employee and spouse complete)	$0 (neither employee nor spouse complete)	$500	$1,000
Primary Covered Member + children[1]	$500	$250 (employee does not complete)	$250	$750
Primary Covered Member + spouse and children[1]	$750 (both employee and spouse complete)	$250 (neither employee nor spouse complete)	$500	$1,250

[1] Includes same gender domestic partner and same-gender domestic partner child(ren) for employees.

[2] This is the only amount that will be placed in your HRA during the calendar year and may be used for any combination of eligible in-network and out-of-network Covered Services.

In order to receive the Health Assessment portion of the HRA funding for each calendar year, the Primary Covered Member and covered spouse/same-gender domestic partner (beginning for 2013) must complete the Health Assessment by December 31 of the previous year. Other covered dependents are not required to complete a Health Assessment. As shown in the tables above, other covered dependents will receive a $250 HRA allocation without completing a Health Assessment, and regardless of whether the Primary Covered Member and/or covered spouse complete the Health Assessment. Refer to the Health Assessment and Biometric Screenings section for instructions on how to complete the Health Assessment.

Note: Health Assessment data will only be used in aggregate for population health management programs

In order to receive the Health Assessment portion of the HRA funding for each calendar year, the Primary Covered Member and covered spouse/same-gender domestic partner (beginning for 2013) must complete the Health Assessment by December 31 of the previous year. Other covered dependents are not required to complete a Health Assessment. As shown in the tables above, other covered dependents will receive a $250 HRA allocation without completing a Health Assessment, and regardless of whether the Primary Covered Member and/or covered spouse complete the Health Assessment. Refer to the Health Assessment and Biometric Screenings section for instructions on how to complete the Health Assessment.

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

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

- $1,500 for Primary Covered Member only coverage
- $3,000 for Primary Covered Member plus spouse (or same gender domestic partner) or plus child(ren) including same-gender domestic partner child(ren)
- $4,500 for family coverage

Note: If you have are new to this Program this year, any remaining funds in the HRA from the previous year will not roll over to the next year until 90 days after the end of the plan year. This is to ensure that your previous claims administrator has access to your prior year HRA funds to pay for claims for medical services received in the previous year but processed during this 90-day window.

New Hires

Sandia will automatically make the full applicable Health Assessment portion of the HRA contribution (maximum of $750) for the calendar year in which you hire. However, to receive the Health Assessment portion of the HRA contribution for the next calendar year, you and your covered spouse/same-gender domestic partner must complete the Health Assessment by December 31.

Eligible Mid-Year Election Change Events

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

- If you have waived coverage because you have coverage elsewhere, and you lose that coverage and enroll in the Sandia Total Health Program within 31 calendar days of the loss of coverage, Sandia will contribute the applicable HRA contribution.
- If you get married mid-year, Sandia will contribute the applicable additional HRA contribution ($250 to include spouse coverage or $500 for family coverage) if you enroll your new eligible family members within 31 calendar days of marriage.
- If two Sandians marry who had separate Sandia Total Health coverage prior to the marriage, and elect Primary Covered Member + Spouse or Primary Covered Member + Family coverage, the total combined HRA funds will be assigned to the Primary Covered Member after approximately ninety (90) days.
- If two Sandians divorce, legally separate, or annul their marriage, the total combined HRA funds will remain with the original Primary Covered Member.

Open Enrollment Changes for Dual Sandians

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

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

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

Events Resulting in Loss of HRA Funds

If you terminate employment, you have up to one year to file claims for expenses incurred while you were employed with Sandia. If you do not use your HRA funds and do not elect COBRA coverage, you forfeit any remaining HRA funds. Refer to the *Sandia Health Benefits Plan for Employees Summary Plan Description* for information on continuing coverage under COBRA.

If you are a pre-Medicare Retiree with no enrolled family members, and you become Medicare-eligible, you have up to one year to file claims for expenses incurred while you were under the Sandia Total Health Program. Any HRA funds remaining after the year will be forfeited.

The maximum balance in an HRA at the beginning of any new year is capped at the amounts described previously. If you have an event which forces you to change coverage, your HRA balance will be adjusted accordingly at the beginning of the next calendar year. For example, you are enrolled as Primary Covered Member + spouse and get divorced during the year. At the time of the divorce you have $2,500 in your HRA. You may keep the HRA funds through the end of the calendar year, but the HRA balance will be reduced to $1,500 - beginning January 1 of the following calendar year, as that is the maximum balance for Primary Covered Member only coverage. Therefore, if you incur an out-of-pocket medical expense of $2,000 in December and you don't file the claim with the claims administrator until January, you will only have the $1,500 in your HRA to cover that medical expense.

What Healthcare Expenses are Eligible for HRA Reimbursement

Your HRA dollars may only be used for Services or eligible prescription drugs and other items as defined in this Program Summary. For example, if you receive elective cosmetic surgery that is not eligible under the Sandia Total Health Program, these claims are not eligible for payment by the HRA.

> **Note:** Dental and vision benefits that you receive through the Sandia Dental Care Program or Vision Care Program are not eligible for reimbursement from your HRA.

How the HRA Works

Your HRA dollars can be used first to pay for Eligible Charges, including eligible prescription drugs purchased through Kaiser Permanente, up to the amount allocated to your HRA. HRA funds are available for use by any covered member and are not apportioned on a per person basis. For example, if there is $750 in available HRA funds and a claim is submitted for one member in the amount of $1,000, and the member has a $750 deductible, the full HRA funds of $750 will be pulled to cover the deductible portion of the claim.

HRA Example 1:

Year 1:

You complete a Health Assessment and you have single coverage at the beginning of the year. Sandia allocates $250 to your HRA. During the course of the year, you incur $150 in eligible medical services. Your In-Network deductible is $750, and the entire $150 of medical services you received is subject to the deductible. You may use your HRA to cover the deductible amount.

HRA Beginning Balance	$250
Less HRA payment	(-$150)
HRA Ending Balance	$100

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

Year 2:

You complete a Health Assessment for this year and have earned additional $100 through the Virgin Health Miles incentive, and you have single coverage at the beginning of the year. Sandia allocates $250 to your HRA. You start the year with a balance of $450 ($100 from the previous year plus $250 from the current year for your HA plus $100 from Virgin HealthMiles). During the course of the year, you incur $100 in Eligible Charges. The entire $100 of Eligible Charges you incurred is subject to the Deductible. Your HRA is used to cover the $100 expense that is applied to your Deductible amount.

Year 1 HRA Carryover Balance	$100
Plus Year 2 HRA	$250
Plus Virgin HealthMiles	$100
Year 2 Beginning Balance	$450
Less HRA payment	(-$100)
Year 2 HRA Ending Balance	$350

- Your HRA is sufficient to cover the entire $100 of your annual healthcare costs. This means that the entire amount that was subject to the Deductible has been paid. For year two, you have no out-of-pocket costs.
- You have $350 of unused funds in your HRA that will roll over to the next calendar year if you continue enrollment in the Sandia Total Health Program.

Year 3:

You complete a Health Assessment for this year and you have earned an additional $100 through the Virgin Health Miles incentive, and you have single coverage at the beginning of the year. Sandia allocates $250 to your HRA. You start the year with a balance of $850 ($350 from the previous year plus $250 from the current year for your HA plus $250 from Virgin HealthMiles). During the course of the year, you incur $1,000 in Eligible Charges. Your HRA is used to cover the $750 deductible as well as the Coinsurance of $250 ($1,000 less $750 (deductible) less $50 (20% Coinsurance of $250).

HRA Carryover Balance	$350
Plus Year 3 HRA	$250
Plus Virgin HealthMiles	$250
Year 3 Beginning Balance	$850
Less HRA payment	(-$800)
Year 3 HRA Ending Balance	$50

- Your HRA is sufficient to cover the entire $1,000 of your annual healthcare costs. This means that the entire amount that was subject to the Deductible has been paid. For year three, you have no out-of-pocket costs.
- You have $50 of unused funds in your HRA that will roll over to the next calendar year if you continue enrollment in the Sandia Total Health Program.

Note: For simplicity, pharmacy expenses were not illustrated in the examples. But prescription medication expenses can also be paid for with the HRA automatically for inpatient medications or using a provided debit card for use at a Network Pharmacy or the mail order pharmacy.

HRA Example 2:

You have enrolled yourself and your spouse and you have completed your Health Assessment for the 2013 calendar year but **your spouse** did not. You do **not** receive your full $500 allotment. You only receive $250. During the course of the year, you incur $500 in Expenses. Your annual deductible is $750. $750 of Expenses are subject to the Sandia Total Health Deductible.

HRA Beginning Balance	$250
Less HRA payment	(-$250)
HRA Ending Balance	$0

- The HRA is used to reimburse $250 of your annual healthcare costs. You had $500 in costs; the first $250 of the Deductible is paid by the HRA. This means that you must pay an additional $250 to meet your annual Sandia Total Health Deductible.
- There is no remaining balance to roll over to the next calendar year.

Claims Processing with an HRA

For Kaiser Permanente Members, PayFlex will issue a debit card for your HRA. This debit card can be used for paying eligible medical and prescription expenses at the point of service.

Note: If you enrolled in a Health Care Flexible Spending Account (HCFSA) the same debit card will be used to pay for eligible FSA expenses. You will use the PayFlex debit card to withdraw funds from your HCFSA to help offset health care expenses you incur under Sandia Total Health as well as Eligible Charges under the HCFSA. Refer to the Flexible Spending Accounts Summary Plan Description for more information.

IMPORTANT: Kaiser Permanente will collect a deposit at the time of service. Your portion (if any) will be paid first from your HCFSA (if you are enrolled), second from your HRA, and third by you.

If you are using a non Network Provider they may require payment at the time of service. In this case you may want to use your debit card to make the payment. Remember that only the amount available in the HCFSA and HRA will be paid.

The Health Care Flexible Spending Account and Health Reimbursement Arrangement will only pay if you have funds available through election for the HCFSA or allocation for the HRA.

Medical Expenses

When you or your covered dependent seeks eligible health care services, you must present your Kaiser Permanente identification card.

If you see an In-Network provider, and if the service requires the deductible or Coinsurance, Kaiser Permanente can run your debit card to see if you have funds in your HCFSA first, then your HRA. If you do, Kaiser Permanente will pull your share of the cost of the service from your PayFlex HCFSA and/or HRA and pay the provider directly.

If you see an Out-of-Network provider, you are responsible for filing the medical claim with PayFlex. PayFlex will look to see if you have funds in your FSA (if you are enrolled) and then your HRA. PayFlex will reimburse you accordingly.

Managing your HCFSA/HRA Claim Submissions

There are several convenient ways to access and use your HCFSA/HRA funds to pay for eligible health care expenses:

- HCFSA/HRA debit card;
- Submit a manual claim to PayFlex for reimbursement.

It is possible you may have unused HCFSA 2010 dollars in your old PayFlex HCFSA, as well as 2011 dollars in your new PayFlex HCFSA. It is up to as to when you submit a manual claim to receive reimbursement from PayFlex. PayFlex will pay out 2010 HCFSA funds first and 2011 HCFSA funds second.

If you only have 2011 HCFSA dollars and 2011 HRA funds, and you need dental work in April, which is why you have set aside 2011 HCFSA dollars, you will not want to use your debit card, as that will deduct funds from your 2011 HCFSA dollars. This could leave you with HCFSA funds to pay for your dental work. 2011 HRA funds cannot be used for dental claims. You will need to submit a manual claim, for your dental work, when the timing is right for you to receive the appropriate reimbursement from PayFlex.

If you expect to have unused HCFSA 2010 dollars in our PayFlex HCFSA and plan to use the grace period for reimbursement for unused funds, you must submit a manual claim to PayFlex.

Remember: You are responsible for managing your HCFSA and HRA funds and the order in which you submit claims, as the payment order is HCFSA first and HRA second. There will be no reversals through PayFlex on the order in which the funds are processed, as that is your responsibility to manage.

Prescription Drugs

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

If you receive In-Network services and you use your debit card to pay your applicable Coinsurance, your Health Care Flexible Spending Account (if you have enrolled in one and have funds available) will be used first. HRA funds will be used second. If no funds are available in either the HCFSA or HRA you will need to pay your Coinsurance through another method.

Note: www.HealthHub.com through PayFlex is designed to provide you with the necessary information and tools you need for your Flexible Spending and Health Reimbursement Accounts. To learn more about HealthHub and your FSA and HRA visit www.HealthHub.com.

Note: You can keep track of the dollars in your HCFSA and HRA by going online to www.HealthHub.com or by calling the toll free number on the back of your PayFlex card.

Health Assessment and Biometric Screenings

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

Biometric Screenings Process

Employees can obtain these screenings either through the Sandia On-Site Clinic (at no cost) or through their primary care physician. To obtain the screenings through the on-site medical clinic, you can schedule an appointment by emailing saludca@sandia.gov or calling 925-294-3500 in California, or by calling HBE Customer Service at 505-844-HBES (4237) in New Mexico.

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

Health Assessment Process for Employees

You will need to register with Virgin HealthMiles to complete your health assessment by going to www.virginhealthmiles.com. Virgin HealthMiles are administered by HBE. HBE can be reached at 505-844-4237.

Virgin HealthMiles Incentive Management Program

Sandia will reward you for getting and staying healthy. You can earn up to an additional $250 towards your Health Reimbursement Account for 2012 through this program. Visit www.virginhealthmiles.com for more details.

Virgin HealthMiles Incentive Management Program

With Virgin HealthMiles, employees and their covered spouses/same-gender domestic partners (in 2012 for 2013) may participate in healthy activities and get rewarded - with better health and with miles! Participants simply track their activities with a *GoZone pedometer* and through the *LifeZone online tracking system*. Visit virginhealthmiles.sandia.gov for more details.

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

Tools and Resources to Become a Wiser Consumer

In addition to the many resources listed in this Program Summary, you can also access important tools and resources from Kaiser Permanente at www.kp.org.

Once you have registered at www.kp.org you can:

- Learn about health conditions, treatments, and procedures
- Search for In-Network Kaiser Permanente facilities in Northern California
- Access health and wellness topics
- Access Nurse Advice Services, 24 hours a day, seven days a week
- Access the provider fee list to estimate the costs of various procedures in your geographical area
- Make real-time inquiries into the status and history of your claims
- View eligibility and benefit information

- View and print EOB statements online
- Update dependent coordination of benefits status

> **Note:** If you have not already registered as a www.kp.org subscriber, go to www.kp.org and click on Sign On. Have your Kaiser Permanente ID card ready.

Prescription

You can obtain the following prescription information at www.kp.org:

- Locate local Network Pharmacies
- Price prescription drugs at Network Pharmacies and mail service
- Refill prescriptions online
- Find out what drugs are covered under the Program

Section 7. Benefits

The Sandia Total Health Program provides a wide range of medical care services for you and your family. This section outlines the benefits available under the Sandia Total Health Program. For detailed explanations of what is covered under each benefit, refer to the information in the table. For information on your prescription drug benefits, refer to Section 8, Prescription Drug Program.

The following information provides detailed descriptions of Services.

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

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

If a health service is not listed in this section as a Service, or in Section 8, What's Not Covered – Exclusions as a specific exclusion, it may or may not be covered. Contact Kaiser Permanente's Customer Service at 800-663-1771 for information.

Acupuncture Services

Acupuncture services are covered as follows:

- X-rays and other Medically Necessary Services provided by a Network Physician, a licensed acupuncturist or doctor of oriental medicine, either In- or Out-of-Network.
- A maximum paid benefit of $750 annually for Covered Services by a Network Physician, a licensed acupuncturist or doctor of oriental medicine per calendar year, per Covered Member. This maximum applies to In- and Out-of-Network acupuncture benefits combined. X-rays do not apply to the maximum benefit.

Auditory Integration Training

The Program recommends the following guidelines for Auditory integration training service:

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

Allergy Services

Services related to allergies are covered as follows:

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

Ambulance Services

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

Ground Ambulance Services

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

Air Ambulance Services

IMPORTANT: You are required to contact customer service as soon as reasonably possible.

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

(Behavioral) Mental Health and Substance Abuse Services

The Sandia Total Health Program covers outpatient mental health and substance abuse Services as follows:

- Evaluations and assessments
- Diagnosis
- Treatment planning

- Referral services
- Medication management
- Individual and group therapeutic services
- Intensive Outpatient Therapy Programs
- Crisis intervention
- Psychological testing, including neuropsychological testing
- Shock therapy

The Sandia Total Health Program covers inpatient, partial hospitalization, and residential treatment facilities for mental health and substance abuse services as follows:

- Services received on an inpatient or partial hospitalization basis in a hospital or an alternate facility that is licensed to provide mental health or substance abuse treatment.
- If you are admitted to a facility and do not meet inpatient criteria, your Network Physician will determine whether you meet partial hospitalization criteria. If you do meet partial hospitalization criteria, only the cost for partial hospitalization in that area will be allowed, and you will be responsible for the remainder of the cost.
- Room and board in a semi-private room (a room with two or more beds).

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

- Two Partial Hospitalization days are counted as one 24-hour hospitalization day.
- Services received in a Residential Treatment Facility as long as there are at least six hours of therapy provided every calendar day.

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

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

Bone Density Testing

The Sandia Total Health Program will pay 100 percent of the Eligible Charges In-Network and 60 percent of the Eligible Charges, after the Deductible, if done Out-of-Network. KP Guidelines for bone density testing are routine screenings begin at age 60 for women who are at increased risk for osteoporotic fractures; women age 65+ not on estrogen and men age 70+ should be screened once using the Fracture Risk Assessment Tool (FRAX). Screening may also be indicated for postmenopausal women under age 65 and men between the ages of 50 and 70 with certain risk factors.

Cancer Screening Services

IMPORTANT:
Kaiser Permanente (Insurance Company) guidelines may differ and override any Sandia guidelines. Your Kaiser Permanente Physician will be the one to determine when you receive preventive care services regardless of the Sandia guidelines below. Kaiser physicians may not recommend the preventive services listed below at the same age that Sandia recommends the services. You will need to discuss this with your Kaiser physician if you have any concerns. It is solely up the discretion of a Kaiser physician to determine when you receive preventive services. If a service is not covered at 100%, you would need to address and resolve with customer Service.

The Sandia Total Health Program will pay 100 percent of the Eligible Charges In-Network and 60 percent of the Eligible Charges, after the Deductible, if done Out-of-Network, for the following services or as Medically Necessary:

Service	Allowed Frequency	Allowable Age
Pap Test	As needed	Upon turning 11
Prostrate Antigen Test	Annual	Upon turning 50
Mammogram*	Baseline, Annual	Between ages 35-39, upon turning 40
Fecal Occult Blood Test	Annual	Upon turning 50
Sigmoidoscopy**	Once every five years	Upon turning 50
Colonoscopy**	Once every ten years	Upon turning 50
Barium Enema***	Once every five years	Upon turning 50

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

** You are entitled to the following:

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

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

Cancer Services

Oncology services are covered as follows:

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

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

Clinical Trials

Services associated with cancer clinical trials are covered if all of the following requirements are met:

- You are diagnosed with cancer
- You are accepted into a phase I, II, III, or IV clinical trial for cancer
- Your treating Network Physician, or your treating Out-of-Network Physician for treatment of cancer recommends participation in the clinical trial after determining that it has a meaningful potential to benefit you
- The Service would be covered if they were not provided in connection with a clinical trial
- The clinical trial has a therapeutic intent, and its end points are not defined exclusively to test toxicity
- The clinical trial involves a drug that is exempt under federal regulations from a new drug application, or the clinical trial is approved by one of the following:
    - National Institutes of Health
    - The federal Food and Drug Administration (in the form of an investigational new drug application)
    - The U.S. Department of Defense
    - The U.S. Department of Veterans Affairs

For Covered Services related to a clinical trial, you will pay the Cost Sharing you would pay if the Service were not related to a clinical trial.

Chiropractic Services

Chiropractic services are covered as follows:

- X-rays and other Services provided by a licensed chiropractor, doctor of oriental medicine, medical doctor, doctor of osteopathy, licensed acupuncturist, or physical therapist either In- or Out-of-Network, with no referral required
- A maximum paid benefit of $750 annually for spinal manipulation treatment per calendar year, per Member. This maximum applies to In- and Out-of-Network benefits combined. All other chiropractic services are not covered.

For Chiropractic and Acupuncture Services Contact:

California Regions
American Specialty Health Plans of California
www.ashcompanies.com
800-678-9133

Dental Care Covered under In-Network and Out-of-Network Medical

Dental Services for radiation treatment

Dental evaluation, X-rays, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck are covered.

Dental anesthesia

For dental procedures, general anesthesia in a hospital or ambulatory surgery center and the Services associated with the anesthesia are covered if any of the following are true:

- You are under age 7
- You are developmentally disabled
- You are not able to have dental care under local anesthesia due to a neurological or medically compromising condition
- You have sustained extensive facial or dental trauma

Other Dental Services

- Orthognathic surgery limited to documented skeletal Class II and Class III conditions as determined by cephalometric diagnosis, provided the condition is:
    1. Both functional and aesthetic
    2. Not adequately treatable by conventional orthodontic therapy
- Dental services related to medical transplant procedures
- Initiation of immunosuppressive therapy
- Direct treatment of cancer or cleft palate

Dental Services (benefit only available Out- of- Network, paid at the In-Network level)

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

- As a result of accidental Injury to sound, natural teeth and the jaw
- As a result of tooth or bone loss, due to a medical condition (e.g., osteoporosis, radiation to the mouth, etc.)
- Dental implants, implant related surgery, and associated crowns or prosthetics are covered in situations where:
    - Permanent teeth are congenitally missing (anodontia), the result of anodontia is impaired function (e.g., chewing/eating), and the implants are not done solely for cosmetic reasons
    - Tooth loss occurs as a result of accidental Injury
    - Tooth loss occurs due to a medical condition such as osteoporosis or radiation of the mouth

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

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

Dental Services for radiation treatment

Dental evaluation, X-rays, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck are covered.

Dental anesthesia

For dental procedures, general anesthesia in a hospital or ambulatory surgery center and the Services associated with the anesthesia are covered if any of the following are true:

- You are under age 7
- You are developmentally disabled
- You are not able to have dental care under local anesthesia due to a neurological or medically compromising condition
- You have sustained extensive facial or dental trauma

Diabetes Services/Devices/Supplies

The Sandia Total Health Program covers diabetes services as follows:

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

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

- Continuous glucose monitoring system criteria includes:
    - Type 1 diabetes or type 2 diabetes requiring basal and bolus insulin AND
    - Willingness to wear the rt-CGM device at least 60% of the time AND
    - Have demonstrated the ability to perform self-monitoring of blood glucose frequently and to adjust the diabetes regimen based on the data obtained with monitoring

- Supplies for external insulin pump and continuous glucose monitoring system.

> **Note:** Continuous Glucose Monitoring Systems (CGMS), Insulin Pump, and CGMS and Insulin Pump supplies are not covered under the Prescription Drug Program.

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

> **Note:** Implantable Insulin pumps are not covered.

Diagnostic Tests

Medically Necessary diagnostic tests are covered as follows:

- Laboratory and radiology
- Computerized Tomography (CT) scans
- Position Emission Tomography (PET) scans
- Magnetic Resonance Imaging (MRI)
- Nuclear medicine
- Echocardiograms
- Electroencephalograms
- Sleep studies
- Other diagnostic tests

Durable Medical Equipment (DME), External Prosthetics and Orthotics DME

Durable medical equipment is covered as follows:

- Ordered or provided by a physician for Outpatient use
- Used for medical purposes
- Not consumable or disposable
- Not of use to a person in the absence of a Sickness, Injury, or disability

- Durable enough to withstand repeated use
- Appropriate for use in the home

Examples of DME include, but are not limited to:

- Wheelchairs
- Hospital Beds
- Equipment for the treatment of chronic or acute respiratory failure or conditions
- Equipment to administer oxygen
- Orthotic appliances when custom manufactured or custom fitted to you
- Oxygen
- Orthopedic shoes (Out-of-Network only, paid at the In-Network level):
    - Up to two pairs of custom-made orthopedic shoes per year when necessary due to illness such as diabetes, post polio, or other such conditions
- Mastectomy bras
    - Up to two bras per calendar year following a mastectomy
- C-PAP machine
- Bilirubin lights
- Braces that stabilize an injured body part and braces to treat curvature of the spine
- Delivery pumps for tube feedings, including tubing and connectors
- Lenses for aphakic patients (those with no lens in the eye) and soft lenses or sclera shells (white supporting tissue of eyeball)

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

More than one piece of DME will be allowed if deemed Medically Appropriate by you Network Physician (e.g., an oxygen tank in the home and a portable oxygen tank).

At your Network Physician's discretion, benefits are provided for the replacement of a type of durable medical if medically necessary. If the purchased/owned DME is lost or stolen, the Sandia Total Health Program will not pay for replacement. The Sandia Total Health Program will not pay to replace leased/rented DME; however, some rental agreements may cover it if lost or stolen.

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

Note: DME is different from prosthetic devices. Refer to Prosthetic Devices in this section.

Education and Training for Self Management

Health education and training for self management is covered when prescribed by a Network Physician and provided by a qualified non physician using a standardized curriculum to teach you how to self manage your disease or condition. Education and training may be provided in group or individual sessions for the following conditions:

- Asthma
- Diabetes
- Coronary artery disease

Emergency Services

Emergency Services include professional, facility and ancillary services such as laboratory, x-ray or imaging services necessary to diagnose and stabilize your condition in an Emergency Department. See the Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers section for more information.

Eye/Vision Services

Eye Exam / Eyeglasses / Contact Lenses

The Sandia Total Health Program covers routine eye exams for non-refractive care due to Sickness or Injury of the eye such as conjunctivitis, diabetic retinopathy, glaucoma, and cataracts, and refractions. An initial pair of contact lenses or glasses when required due to the loss of a natural lens or cataract surgery available Out-of-Network only, covered at the In-Network level is allowed.

Comprehensive Vision Examination

Describes a level of service in which a general evaluation of the complete visual system is made. The comprehensive services constitute a single-service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examination, gross visual fields and basic sensorimotor examination. It often includes, as indicated, biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of a diagnostic and treatment program as indicated.

If you go In-Network through Kaiser Permanente for a Comprehensive Vision Examination, including refraction, the exam is covered as follows: Covered at a $20 co-pay, no deductible In-Network.

If you go Out-of-Network, for an eye exam, you will receive $30 reimbursement toward the Out-of-Network exam.

Employees and their covered dependents that are enrolled in the Sandia Vision Care Program are eligible to receive services related to refractive care under that program. Refer to the Vision Care Program (VCP) Summary.

Family Planning

- Sterilization procedures such as vasectomies and tubal ligations
- Medically Appropriate ultrasounds and laparoscopies
- Family planning devices that are implanted or injected by the physician such as IUDs, Norplant, or Depo-Provera
- Reversals of prior sterilizations available. Performed Out-of-Network only, but covered as in-network and paid at 80% after deductible has been met. See section, In-Network and Out-Of-Network Options for cost sharing information
- 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.

Genetic Testing

The Sandia Total Health Program covers medically necessary genetic testing. Examples of covered genetic tests include testing related to breast and ovarian cancer. Genetic testing for breast cancer is covered under Preventive Care.

Hearing Aids

Sandia will cover one hearing aid per hearing-impaired ear every thirty-six months for dependent children under the age of 21. The benefit is unlimited in-network and out-of-network, as follows:

In-Network

- The Member must satisfy $750 annual deductible, before co-insurance payments begin.
- Once the $750 annual deductible is met, the Plan pays 80% coinsurance and the Member pays 20% coinsurance.
- The Member's annual out of pocket maximum is $2,250 (includes $750 deductible).

Out- of-Network

- Member must satisfy $2,000 annual deductible, before co-insurance payments begin.
- Once the $2,000 annual deductible is met, the Plan pays 60% coinsurance and the Member pays 40% coinsurance.
- The Member's annual out of pocket maximum is $6,000 (includes $2,000 deductible).

In addition, this coverage shall include fitting and dispensing services, including providing ear molds as necessary to maintain optimal fit, provided by a licensed audiologist, a hearing aid dispenser or a physician.

Home Health Services

Covered Services are services that are Medically Necessary when you are confined to your home. Services must be:

- Ordered by a Network Physician or an Out-Of-Network physician.
- Provided by or supervised by nurses, medical social workers, and physical, occupational and speech therapists in your home.
- The Services are covered only if a Network Physician or an Out-of-Network Provider determines that you require skilled care and it is feasible to maintain effective supervision and control of your care in your home. Home health aide Services are covered only when you are also getting covered home health care from one of the licensed providers mentioned previously.

Home Infusion Services

Home infusion therapy is the administration of drugs in your home using intravenous, subcutaneous, and epidural routes (into the bloodstream, under the skin, and into the membranes surrounding the spinal cord). Home infusion includes intravenous delivery of parenteral nutrition when nutritional needs cannot be met by the oral or enteral route as determined by a Network Physician. The infusion therapy must be delivered by a licensed pharmacy. Home Services are also provided to ensure proper patient education and training and to monitor the care of the patient in the home. These Services may be provided directly by infusion pharmacy nursing staff or by a qualified home health agency. You do not need to be confined to your home to receive home infusion Services. The following are covered home infusion Services:

- Administration
- Professional pharmacy Services
- Care coordination
- All necessary supplies and equipment, including delivery and removal of supplies and equipment
- Drugs and Biologicals
- Nursing visits related to infusion

Hospice

Hospice care is covered as follows:

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

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

Infertility Services

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

A maximum lifetime benefit of $30,000 per Covered Member is allowed for infertility treatments. This maximum is accumulated from any expenses, except prescription drugs, related to infertility treatment paid following a confirmed diagnosis of infertility. Expenses for infertility services incurred without a diagnosis of infertility will not be reimbursed. There are limitations to eligible procedures (refer to the General Exclusions, General Limitations, Coordination of Benefits, and Reductions section).

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 Appropriate laparoscopies and ultrasounds
- Artificial insemination
- In Vitro Fertilization
- Gamete intrafallopian transfers (GIFT)
- Zygote intrafallopian transfers (ZIFT)
- Embryo transplantation
- Laparoscopies for egg retrieval
- Infertility
- Purchase of eggs and sperm See the In-Network and Out-Of-Network Options section for cost sharing information.
- 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) available Out-of-Network only. See the In-Network and Out-Of-Network Options section for cost sharing information.
- Storing and preserving embryos for up to two years available. See the In-Network and Out-Of-Network Options section for cost sharing information.

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.

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

Injections in Physician's Office

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

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

Inpatient Care

Inpatient Covered Services in a hospital are as follows:

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

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

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

If you are admitted to a hospital for an Emergency Medical Condition that is not in the network and services are covered, In-Network benefits will be paid until you are Stabilized. Once Stabilized, you must be moved to a network hospital to continue In-Network benefits. You may elect to remain in the Out-of-Network hospital and receive Out-of-Network benefits, as long as a Network Physician confirms the treatment to be Medically Necessary.

Surgeries (resulting in an inpatient stay) performed outside the United States will be covered at the Out-of-Network level of benefits if they are considered a covered procedure.

Maternity Services

IMPORTANT: Newborn and Mother's Health Protection Act: Under federal law, mothers and their newborns that are covered under group health plans are guaranteed a stay in the hospital of not less than 48 hours following a normal delivery or not less than 96 hours following a cesarean section. Refer to Section 3, How to Obtain Services.

Maternity services are covered as follows:

- Initial visit to the physician to determine pregnancy status
- Pre-natal and post-natal visits
- Charges related to delivery

Newborn

If the newborn is not enrolled in the Program eligibility records, via the normal enrollment process by the Program, the newborn claim(s) will denied by the payor as non-covered or provided to a non-member. This claims administration policy applies to services that are billed under the newborn Medical Record Number (MRN) only. Once enrollment occurs, newborn claims will be reprocessed and paid under the specified benefits.

Newborn services billed under the parent's MRN will be adjudicated according industry standard practices (well baby facility charges can be billed under parental MRN, but well baby professional charges and all sick baby charges should be billed under the newborn MRN).

If the newborn enrollment has not been completed by the time the newborn claim is received by the Program, the claim will be denied. The EOB will indicate that newborn needs to be enrolled, serving as a reminder for the parents to enroll the newborn. Once enrollment occurs, newborn claims will be reprocessed and paid under the specified benefits. No additional actions are required by the member.

Licensed birthing centers are covered to include charges from the birthing center, physician, midwife, surgeon, assistant surgeon (if Medically Necessary), and anesthesiologist. Benefits for birthing services rendered in the home will be paid at the In-Network cost sharing.

Refer to the Preventive Care section for information on preventive services related to maternity.

Pregnancy-Related Preventive Care Services

Sandia recommends the following preventive care benefit guidelines and schedules to obtain preventive care services listed below. The Sandia Total Health Program will not cover all care that is preventive in nature, but will cover certain services under the preventive care benefit.

IMPORTANT: Your Kaiser Permanente Physician will be the one to determine when you receive pregnancy-related preventive care services regardless of the Sandia guidelines below. You will need to discuss this with your Kaiser physician if you have any concerns. It is solely up the discretion of a Kaiser physician to determine when you receive pregnancy-related preventive services. Without the physician's determination your pregnancy-related preventive services will not be paid at 100%. If a service is not covered at 100%, you would need to address and resolve with Kaiser Permanente directly.

The Sandia Total Health Program will pay 100 percent of the Eligible Charges In-Network and 60 percent of the Eligible Charges, after the Deductible, if done Out-of-Network, for the following pregnancy-related services, on an as needed basis:

- Multiple marker screening between weeks 15 and 18 for pregnant women age 35 and older
- Serum alpha-fetoprotein between weeks 16 and 18 based on personal risk factors

- Chorionic villus sampling before week 13 or amniocentesis between weeks 15 and 18 in women who are 35 and older and at risk for passing on certain chromosomal disorders
- Hemoglobiopathy screening if at risk for passing on certain blood disorders
- Screening for gestational diabetes between 24 and 28 weeks
- Screening for group B strep between 35 and 37 weeks
- Anemia screening on a routine basis
- Bacteriuria urinary tract or other infection screening
- Breast feeding interventions to support and promote breast feeding
- Hepatitis B screening at first prenatal visit
- Rh incompatability screening and follow-up testing for women at higher risk
- Syphillis screening
- Tobacco use screening and counseling as needed

Healthy Pregnancy Services

Kaiser Permanente offers a variety of classes to help you through your pregnancy. These are some classes you may volunteer to participate in:

- First Prenatal Visit refresher
- Healthy Beginnings: Late Pregnancy
- Healthy Beginnings: Mid Pregnancy
- Hospital Maternity Tour
- Labor Preparation
- Mom and Me Smoke-free
- Mood Changes in Pregnancy
- New Pregnancy
- Newborn Care
- Orientation: Pregnancy
- Prenatal Lecture Series
- Prenatal Nutrition and Exercise
- Prenatal Yoga
- Preparing for Fatherhood
- Teen Pregnancy

Class selection differs by facility; class times and offerings may change without notice. Please check www.kp.org for the most current information.

Medical Supplies

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

- Ostomy supplies
- Compression stockings (6 pair)
- Aero chambers, aero chambers with masks or nebulizers (you can obtain these either under the medical benefits or the Prescription Drug Program but not both)
- Lancets, Alcohol swabs, diagnostic testing agents, syringes, Novopen and insulin auto-injectors, and allergic Emergency kits can be obtained under the prescription drug benefits

Nutritional Counseling

Nutritional counseling is individualized advice and guidance for Members who are at nutritional risk due to nutritional history, current dietary intake, medication use or chronic illness. Nutritional Counseling provides options and methods for improving nutritional status.

Covered Services include certain services provided by a registered dietician in an individual setting if you have a medical condition that requires a special diet. Some examples of such medical conditions include:

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

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

Obesity Surgery – Bariatric Surgery

Bariatric Surgery is provided under the direction of a physician and will be covered provided all of the following are true:

- You have a Body Mass Index (BMI) greater than 40
- BMI 35-40 with a serious obesity related health problem (ex: type 2 diabetes, coronary heart disease or severe sleep apnea)
- Expectable operative risks per ACC guidelines
- An ability to participate in treatment and long term follow-up
- Ability to exercise
- Able to demonstrate an understanding of the operation, risk and benefits, and long term lifestyle changes.

Office Visits - Outpatient Services

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

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

Other Outpatient Services

The following outpatient care is covered for Services to diagnose or treat an, injury or disease:

- House calls by a Network Physician when care can best be provided in your home
- Infusion Services provided in an outpatient setting

Organ Transplant Services

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

- Cornea
- Heart
- Heart/lung
- Lung Kidney
- Pancreas after kidney or simultaneous pancreas/kidney
- Liver
- Liver/kidney
- Small bowel/liver
- Pancreas transplant alone
- Bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy.

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

Covered Services include:

- In-Network only reasonable transportation and lodging expenses outside of the Service Area when approved in advance by Kaiser Permanente. Coverage will include the transplant recipient plus, one parent or guardian if the transplant recipient is a minor or one other person if the transplant recipient is an adult.
- Reasonable medical and hospital expenses of an organ/tissue donor which are directly related to a covered transplant are covered only if such expenses are incurred for Services within the United States or Canada. Coverage of expenses for these Services is subject to Donor Service Guidelines.
- Per diem reimbursement for daily expenses (includes meals, ground transportation, and any other expenses). The allowance will be paid for all days that Kaiser Permanente determines the Member Recipient must be at the facility and all days that Kaiser Permanente determines are reasonably required for travel to or from the facility. The Participant recipient will not receive an allowance while an inpatient. Other than the allowance, Kaiser Permanente will not pay for any personal expenses, such as phone calls. Reimbursement will be retrospective.

Limitations:

- Lifetime In-Network Limit Maximum for Transportation and Lodging is $10,000.
- The per diem reimbursement for daily expenses is $50 per eligible person (transplant recipient plus, one parent or guardian if the transplant recipient is a minor or one other person if the transplant recipient is an adult.), maximum $100 per day.
- The Program does not assume responsibility for providing or assuring the availability of a donor or donor tissue/organs.

Outpatient Surgical Services

Outpatient Surgery and related services are covered as follows:

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

Surgeries performed outside the United States will be covered at the Out-of-Network level of benefits if they are considered a covered procedure.

Special Oral Foods (Medical Foods)

Special oral foods are foods that are prescribed by a Network Provider and used in the treatment of certain medical conditions, such as phenylketonuria (PKU) and other inherited diseases of amino acids and organic acids caused by genetic defects that can lead to life threatening abnormalities in body chemistry. Special oral foods are not foods that are generally available in retail grocery stores. Special oral foods are not used with feeding tubes. For coverage of nutritional formulas delivered via a feeding tube see the Durable Medical Equipment, External Prosthetics and Orthotics heading in this "Benefits and Cost Sharing" section.

Preventive Care

Sandia recommends the following preventive care benefit guidelines and schedules to obtain preventive care services listed below. The Sandia Total Health Program will not cover all care that is preventive in nature, but will cover certain services under the preventive care benefit.

IMPORTANT: Kaiser Permanente (Insurance Company) guidelines may differ and override any Sandia guidelines. Your Kaiser Permanente Physician will be the one to determine when you receive preventive care services regardless of the Sandia guidelines below. Kaiser physicians may not recommend the preventive services listed below at the same age that Sandia recommends the services. You will need to discuss this with your Kaiser physician if you have any concerns. It is solely up the discretion of a Kaiser physician to determine when you receive preventive services. If a service is not covered at 100%, you would need to address and resolve with customer Service.

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

Preventive care refers to measures taken to prevent diseases rather than curing them or treating their symptoms. Preventive care:

1. protects against disease such as in the use of immunizations,
2. promotes health, such as counseling on healthy lifestyles and
3. detects disease in its earliest stages before noticeable symptoms develop such as screening for breast cancer.

IMPORTANT: In order to receive the preventive care benefit, the service must be submitted with a preventive ICD-9 diagnostic code. If it is submitted with a non-preventive ICD-9 diagnostic code, the service will be reimbursed at the applicable benefit level. Routine annual physical exams will be covered under the preventive benefit, even if billed with a non-preventive IDC-9 diagnostic code, so long as a preventive ICD-9 diagnostic code is also billed.

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

Well Baby Care (0-2 years)

The Sandia Total Health Program will pay 100 percent of the Eligible Charges In-Network and 60 percent of the Eligible Charges, after the Deductible, if done Out-of-Network for the following services:

- Routine physical exams (including height and weight) at birth, one, two, four, six, nine, 12, 15, 18, and 24 months
- Autism screening at 18 and 24 months
- Behavioral assessment as needed
- Congenital hypothyroidism screening for newborns
- Development screening as needed - surveillance throughout childhood as needed
- Fluoride chemoprevention supplements older than six months whose primary water source is deficient in fluoride (refer to Section 7, Prescription Drug Coverage)
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screenings as needed
- Hematocrit or hemoglobin screening as needed
- Hemoglobinopathies or sickle cell screening for newborns
- Lead screening as needed
- Phenylketonuria (PKU) screening in newborns
- Thyroid screen as needed
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening as needed

Refer to the Immunizations/Vaccines/Flu Shot Services section for information on these covered services.

Well Child Care (3-10 years)

The Sandia Total Health Program will pay 100 percent of the Eligible Charges In-Network and 60 percent of the Eligible Charges, after the Deductible, if done Out-of-Network for the following services:

- One routine physical/annual exam (including height, weight, and body mass index measurements) is allowed each calendar year, regardless of the date of the previous routine physical/annual exam, and no more frequently than one per calendar year. Allowable exams include routine preventive physicals, including annual exams and sports physicals.
- Behavioral assessment as needed
- Development screening as needed - surveillance throughout childhood as needed
- Dyslipidemia screening for children at higher risk of lipid disorders
- Fluoride chemoprevention supplements for children, age five or younger, whose primary water source is deficient in fluoride (refer to Section 7, Prescription Drug Coverage)

- Hearing screenings as needed
- Hematocrit or hemoglobin screening as needed
- Lead screening as needed
- Obesity screening and counseling as needed
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening as needed

Refer to the Immunizations/Vaccines/Flu Shot Services section for information on these covered services.

Well Adolescent Care (11-18 years)

The Sandia Total Health Program will pay 100 percent of the Eligible Charges In-Network and 60 percent of the Eligible Charges, after the Deductible, if done Out-of-Network for the following services:

- One routine physical/annual exam (including height, weight, and body mass index measurements) is allowed each calendar year, regardless of the date of the previous routine physical/annual exam, and no more frequently than one per calendar year. Allowable exams include routine preventive physicals, including annual exams and sports physicals.
- Alcohol and drug use assessment as needed
- Behavioral assessment as needed
- Blood pressure testing
- Chlamydia infection screening as needed
- Cervical dysplasia screening as needed for sexually active females
- Development screening as needed - surveillance throughout childhood as needed
- Dyslipidemia screening for children at higher risk of lipid disorders
- Hematocrit or hemoglobin screening as needed
- HIV screening at higher risk as needed
- Lead screening as needed
- Obesity screening and counseling as needed
- Rubella screening (once per lifetime)
- Sexually transmitted infection prevention counseling for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening as needed

Refer to the Immunizations/Vaccines/Flu Shot Services section for information on these covered services.

Well Adult Care (19 and older)

The Sandia Total Health Program will pay 100 percent of the Eligible Charges In-Network and 60 percent of the Eligible Charges, after the Deductible, if done Out-of-Network for the following services:

- One routine physical/annual exam (including height, weight, and body mass index measurements) is allowed each calendar year, regardless of the date of the previous routine physical/annual exam, and no more frequently than one per calendar year. Allowable exams include routine preventive physicals, including annual exams and sports physicals.
- Abdominal aortic aneurysm one-time screening for men between the ages of 65 and 74 who have ever smoked
- Alcohol misuse screening and counseling as needed
- Aspirin use (refer to Section 7, Prescription Drug Coverage)
- Blood pressure screening as needed
- BRCA counseling about genetic testing for women at higher risk
- Breast cancer chemoprevention counseling for women at higher risk
- Cervical cancer screening for sexually active women
- Chlamydia infection screening as needed
- Depression screening as needed
- Diet counseling for adults at higher risk for chronic disease
- Folic acid supplements for women who may become pregnant (refer to Section 7, Prescription Drug Coverage)
- Gonorrhea screening for women at higher risk
- HIV screening for adults at higher risk as needed
- Obesity screening and counseling as needed
- Rubella screening (once per lifetime)
- Sexually transmitted infection prevention counseling for adults at higher risk
- Syphillis screening for adults at higher risk as needed
- Tobacco use screening as needed and cessation interventions for tobacco users
- Well woman exam annually

Refer to the Immunizations/Vaccines/Flu Shot Services, Cancer Screening Services, Laboratory Services, and Bone Density Testing sections for information on these covered services.

Laboratory Services

The Sandia Total Health Program will pay 100 percent of the Eligible Charges In-Network and 60 percent of the Eligible Charges, after the Deductible, if done Out-of-Network, for the following laboratory services for those ages 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, squamous epithelial, calcium oxylate
- Complete metabolic profile, which includes sodium, potassium, chloride, CO2, anion, glucose, bun, creatinine, calcium, total protein, albumin, globulin, bilirubin total, alkphos, asp, alt
- Diabetes screening, which includes a two-hour postprandial blood sugar and HbA1c
- Thyroid screening, which includes free T4 and TSH
- Lipid panel, which includes triglycerides, total cholesterol, HDL, and calculated LDL cholesterol

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

Immunizations/Vaccines/Flu Shot Services

The Sandia Total Health Program will pay 100 percent of the Eligible Charges In-Network and 60 percent of the Eligible Charges, after the Deductible, if done Out-of-Network for immunizations, vaccines, and flu shots, as well as immunizations related to personal travel. at the physician's office (e.g., malaria pills). Preventive immunizations include:

- Gardasil (HPV)
- Hepatitus A and B vaccine
- Immunizations / Vaccines including immunizations for travel
- Influenza vaccine
- Meningococcal vaccine
- Pneumococcal vaccine
- Zostvax (Shingles)

Office visit cost share may apply if immunizations are not received during a preventive visit.

Professional Fees for Surgical Procedures

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

This Program will pay the following surgical expenses:

- A surgeon will not be paid as both a co-surgeon and an assistant surgeon.
- Expenses for certified first assistants are allowed.
- Incidental procedures are those services carried out at the same time as a more complex, primary procedure. The incidental procedure may be a part of the primary procedure and require little or very little additional time and resources; therefore, they are usually not covered.
- A surgical procedure that is performed and not considered incidental to the primary procedure will be reimbursed at half of the allowable. For example: When bilateral surgical procedures are performed by one or two surgeons, the Sandia Total Health Program will consider the first procedure at the full allowed amount, and the second procedure will be considered at half of the allowed amount of the listed surgical unit value
- Foot surgery – for a single surgical field/incision or two surgical fields/incisions on the same foot, the Program will allow the full amount for the procedure commanding the greatest value; half of the full amount for the second procedure; half of the full amount for the third procedure; and a quarter of the full amount for each subsequent procedure.

Prosthetic Devices/Appliances

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

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

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

Benefits are provided for the replacement of each type of prosthetic device. Prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement, if the device or appliance breaks, or is otherwise irreparable. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part. If the appliance is lost or stolen, the Sandia Total Health Program may not pay for replacement unless the device or appliance is at least five years old.

Reconstructive Procedures

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

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

Correction of congenital hemangioma (known as port wine stain) is limited to hemangiomas of the face and neck for children aged 18 years and younger.

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

Rehabilitation Services (Outpatient Therapies)

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

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

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

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

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

Skilled Nursing Facility Services

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

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

> **Note:** The Sandia Total Health Program will pay the difference in cost between a semi-private room and a private room only if a private room is Medically Necessary.

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 a sickness or injury that would have otherwise required an inpatient stay in a hospital.

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

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

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

Temporomandibular Joint (TMJ) Syndrome

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

Urgent Care Services

The Program will cover Urgent Care as follows:

- If you receive care at an In-Network Urgent Care Facility within the United States, you will be reimbursed under the In-Network level of benefits.
- If you receive care at an Out-of-Network Urgent Care Facility within the United States, you will be reimbursed under the In-Network level of benefits
- If you are traveling outside the United States, your claim will be processed at the In-Network benefit level.
- Follow-up care while traveling outside the United States will be covered at the Out-of-Network level of benefits
- Follow-up care while traveling within the United States will be covered at the applicable In-Network level of benefits only if the place of care is not located within a service area of any In-Network provider.

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Section 8. Prescription Drug Program

Some Kaiser Permanente Pharmacies may not be able to fill or refill a prescription from an Out-of-Network Provider. To locate a Network Pharmacy, view the formulary, learn more about mail order or print a claim form, visit the kp.org or call 866-427-7701.

Outpatient Prescription Drugs

Outpatient drugs, supplies, and supplements are covered when all of the following requirements are met:

- The item is prescribed by a Network Provider or an Out-of-Network Provider authorized to prescribe drugs or by one of the following Non-Network Providers:
    - A dentist
    - A Non-Network Provider
    - A Non-Network Provider if you got the prescription in conjunction with Covered Services
- The item is prescribed in accordance with Kaiser Permanente drug formulary guidelines.
- The item is one of the following:
    - Drugs that don't require a prescription but are listed on Kaiser Permanente's drug formulary.
    - Diabetic supplies such as insulin, syringes, pen delivery devices, blood glucose monitors, test strips and tablets. Other diabetic supplies may be covered under Durable Medical Equipment.
    - Emergency contraceptives (up to age 17)
    - Growth hormone
    - Smoking cessation drugs

Kaiser Permanente uses a formulary. A formulary is a list of drugs that have been approved for coverage by the Pharmacy and Therapeutics Committee. The drug formulary guidelines allow you to obtain non formulary prescription drugs (those not listed on the drug formulary for your condition) if they would otherwise be covered if pharmacy criteria are met. Prescriptions written by dentists are not eligible for non formulary exceptions.

The prescribing physician or dentist determines how much of a drug, supply, or supplement to prescribe. For purposes of day supply coverage limits, the formulary includes a pre-determined amount of an item that constitutes a Medically Necessary day's supply. The pharmacy may reduce the day supply dispensed to a 30-day supply in any 30-day period if the pharmacy determines that the item is in limited supply in the market or for specific drugs (the Pharmacy can tell you if a drug you take is one of these drugs). Note: episodic drugs prescribed for the treatment of sexual dysfunction disorders may be limited by number of doses within a 30-day period.

Mail Order Service, subject to any Limitations, Copayments and Deductibles, is available. Not all drugs are available through the mail order service. Examples of drugs that cannot be mailed include:

- Controlled substances as determined by state and/or federal regulations
- Medications that require special handling
- Medications affected by temperature

Refills may be ordered from Kaiser Pharmacies, the mail-order program, or online at www.kp.org. A Kaiser Pharmacy can provide more information about obtaining refills.

To locate a Network Pharmacy, view the formulary, learn more about mail order or print a claim form, visit www.kp.org or call 866-427-7701.

Covered Preventive Medications

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

- One aspirin per day (generic only) to prevent cardiovascular disease as follows:
  - Aspirin 81 mg to 325 mg
  - Aspirin chew 81 mg to 325 mg
  - Aspirin delayed release 81 mg to 325 mg
  - Aspirin dispersible tab 81 mg
- Oral fluoride supplementation (prescription only) for children between the ages of 6 months and 5 years whose primary water source is deficient in fluoride as follows:
  - Sodium fluoride tab 0.5 mg
  - Sodium fluoride chew tab 0.25 mg to 0.5 mg
  - Sodium fluoride solution
- Folic acid tab 0.4 mg and 0.8 mg (one per day) for women 55 years of age or younger
- Immunizations/vaccines
- Iron supplementation for children birth to 12 months of age as follows:
  - Iron suspension
  - Ferrous sulfate elixir, syrup and solution
- Tobacco cessation products as follows:
  - Nitrol NS
  - Zyban
  - Chantix
  - Nicotine patches

Prescriptions Subject to Quantity Limits

A Quantity Limit is a limitation on the number (or amount) of a prescription medication covered within a certain time period. Quantity Limits are established to ensure that prescribed quantities are consistent with clinical dosing guidelines, to control for billing errors by pharmacies, to encourage dose consolidation, appropriate utilization and to avoid misuse/abuse of the medication. Established quantity limits are based on the Federal Drug Administration and manufacturer dosing recommendations and/or current literature. Prescriptions written for quantities in excess of the established limits will require a Prior Authorization before the prescription can be filled. The following prescriptions or therapeutic class of prescriptions are subject to Quantity Limits. This list is not all-inclusive and is subject to change:

- Emergency contraceptive (e.g., Plan B) limited to two per year
- Epi-Pen (limited to three per year)
- Glucagon auto-injection (limited to two per year)
- Insulin auto injectors (limited to two per year)
- Lovenox (limited to seven days/14 injections)
- Nicotrol Nasal Spray (three inhaler kits per 30 days with a maximum of 360 days per lifetime)
- Sexual dysfunction drugs (e.g., Viagra) are limited to males only and eight pills/30 days at retail or 24 pills/90 days at mail
- Sleep aids (e.g., Ambien) are limited to 15 pills/30 days at retail or 45 pills/90 days at mail
- Relenza diskhaler (one per year)
- Tamiflu (ten capsules per year)

Kaiser Permanente Mail-Order Program (For maintenance prescription drugs)	Kaiser Network Retail Pharmacies	Out-of-Network Retail Pharmacies
Coinsurance of 20% of mail order price with a $10 minimum and $20 maximum for **generic** prescription drugs	Coinsurance of 20% of retail discount price with a $5 minimum and $10 maximum for **generic** prescription drugs	50% reimbursement
Coinsurance of 30% of mail order price with a $50 minimum and $80 maximum for **preferred brand** name prescription drugs	Coinsurance of 30% of retail discount price with a $25 minimum and $40 maximum for **preferred brand** name prescription drugs	50% reimbursement
Coinsurance of 40% of mail order price with a $80 and $120 maximum for **non-preferred brand name** prescription drugs	Coinsurance of 40% of retail discount price with a $40 minimum and $60 maximum for **non-preferred brand name** prescription drugs	50% reimbursement
Maximum of 90-day supply	Maximum of 30-day supply	Maximum of 30-day supply
Out-of-Pocket Maximum is $1,500 per person per year. Refer to Section 4, Deductibles and Maximums for more information.		Out-of-Pocket Maximum does not apply
Coinsurance does not apply to the Sandia Total Health Program medical Deductible and/or Out-of-Pocket Maximum. Reimbursement for prescriptions purchased outside the United States will be reimbursed at the applicable retail Coinsurance, limited to a maximum of a 30-day supply.		

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Section 9. Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers

This section explains how to obtain covered emergency, post-stabilization, and out of area Urgent Care from non–Network Providers.

You do not need to get Prior Authorization from Kaiser Permanente to get Emergency Services or Urgent Care outside the Service Area from non–Network Providers. However, you (or someone on your behalf) must get Prior Authorization from Kaiser Permanente to get covered Post-Stabilization Care from Non–Network Providers to be covered at the In-Network level.

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital emergency department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Network Providers or Non-Network Providers anywhere in the world, as long as the Services would have been covered under the Benefits and Cost Sharing section (subject to the General Exclusions, General Limitations, Coordination of Benefits, and Reductions section).

Emergency Services are available from Hospital emergency departments 24 hours a day, seven days a week.

For ease and continuity of care, you are encouraged to go to a Network Hospital emergency department if you are inside the Service Area, but only if it is reasonable to do so, considering your condition or symptoms. If you have been admitted to a Non-Network hospital, your stay will be covered at the In-Network level if Kaiser Permanente is notified within 24 hours or as soon as reasonably possible of stabilization of your condition.

Post-Stabilization Care

Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable. Post-Stabilization Care received from a Non–Network Provider, including inpatient care at a non–Network Hospital, is covered at the In-Network level only if Kaiser Permanente provides Prior Authorization for the care.

To request Prior Authorization to receive Post-Stabilization Care from a Non–Network Provider, you (or someone on your behalf) must call Kaiser Permanente toll free at the telephone number on your Kaiser Permanente ID card before you receive the care if it is reasonably possible to do so (otherwise, call as soon as reasonably possible). A Kaiser Permanente representative will then discuss your condition with the Non–Network Provider. To be covered at the In-Network level, if Kaiser Permanente decides that you require Post-Stabilization Care and that this care would be covered if you received it from a Network Provider, they will authorize your care from the Non–Network Provider or arrange to have a Network Provider (or other designated provider) provide the care. If Kaiser Permanente decides to have a Network Hospital, Network Skilled Nursing Facility, or designated Non–Network Provider provide your care, they may authorize special transportation services that are medically required to get you to the provider. If this occurs, then

those special transportation services will be covered, even if they would not be covered at the In-Network rate under Ambulance Services in the Benefits and Cost Sharing section if a Network Provider had provided them.

Be sure to ask the Non–Network Provider to tell you what care (including any transportation) Kaiser Permanente has authorized, because unauthorized Post-Stabilization Care or related transportation provided by Non–Network Providers is not covered at the In-Network level.

Sometimes extraordinary circumstances can delay your ability to call Kaiser Permanente to request authorization for Post-Stabilization Care from a Non–Network Provider (for example, if you are unconscious, or if you are a young child without a parent or guardian present). In these cases, you (or someone on your behalf) must call Kaiser Permanente as soon as reasonably possible.

Services Not Covered at the In-Network level under this Section

The following Services are not covered under this "Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers" section (instead, refer to the Benefits and Cost Sharing section):

- Services that are not Emergency Services, Post-Stabilization Care, or Urgent Care that you receive outside the Service Area, even if those Services are related to your Emergency Medical Condition.
- Emergency Services, Post-Stabilization Care, and Urgent Care that you receive from Network Providers

Payment and Reimbursement

If you receive Emergency Services, Post-Stabilization Care, or Urgent Care outside the Service Area from a Non–Network Provider, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us. To request payment or reimbursement, you must file a claim as described in the Benefits and Cost Sharing section.

Cost Sharing

The Cost Sharing for Emergency Services, Post-Stabilization Care, and Urgent Care outside the Service Area that you receive from a Non–Network Provider is the Cost Sharing required for the same Services provided by a Network Provider. Your required Cost Sharing will be subtracted from any payment made to you or the Non–Network Provider.

Section 10. Definitions

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

In this Summary Members and Dependents may be referred to as "you" or "your."

Term	Definition
Allowance	A dollar amount the Program will pay for benefits for a service during a specified period of time. Amounts in excess of the Allowance, are your responsibility to pay and do not apply toward your Out-of-Pocket Maximum.
Claims Administrator	KPIC is the self-funded claims administrator. You can find the Claims Administrator's address in the "Customer Service Phone Numbers" section and on your Kaiser Permanente ID card.
Clinically Stable	You are considered Clinically Stable when your treating physician believes, within a reasonable medical probability and in accord with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during, or as a result of, the discharge or transfer.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985.
Coinsurance	The percentage of a Service which the Program Permanente pays after you have met the Deductible.
Copayment	A specified dollar amount that you must pay for certain If you have outstanding receipts for healthcare expenses incurred in 2011, all requests for reimbursement will be accepted and processed through April 15. After April 15, funds remaining in your 2011 Health Care Flexible Spending Account will be forfeited. Covered Services.
Cost Sharing	Copayments, Coinsurance and Deductibles.
Covered Service	Services that meet the requirements for coverage described in this Summary.
Deductible	Eligible Charges incurred during a calendar year that you must pay in full before the Sandia Total Health Program pays benefits. Does not apply to outpatient prescription drugs purchased through Kaiser Permanente.
Dental Services	Items and Services provided in connection with the care, treatment, filling or removal, or replacement of teeth or structures directly supporting the teeth. (Structures supporting the teeth mean the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth and alveolar process.)
Dependent	A person who is enrolled in the Program if the person's relationship to the Member is the basis for eligibility. This Summary sometimes refers to a Dependent or Member as "you."

Term	Definition
Durable Medical Equipment (DME)	Durable Medical Equipment (DME) is a device or instrument of a durable nature that meets all of the following requirements: • It can withstand repeated use; • It is primarily and customarily used to serve a medical purpose; • It is generally not useful to a person in the absence of illness or injury; and • It is appropriate for use in your home.
Eligible Charges	• For Services provided by Kaiser Permanente, the charge in the relevant Kaiser Foundation Health Plan's schedule of Kaiser Permanente charges for Services provided to participants • For Services that Network Providers (other than Kaiser Permanente) provide under a contract with Kaiser Permanente, the amount that the provider has agreed to accept as payment in full under that contract • For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge you for the item if your benefits did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs and other items, the direct and indirect costs of providing Kaiser Permanente pharmacy Services, and the pharmacy program's contribution to the net revenue requirements of the relevant Kaiser Foundation Health Plan) • For all other Services, the amounts that the Program pays for the Services or, if the Program subtracts Cost Sharing from its payment, the amount the Program would have paid if it did not subtract Cost Sharing. For non-emergency Out-of-Network Provider Services the Program will pay in the 90th percentile of UCR charges. The Member will pay their Coinsurance based on the 90th percentile of UCR AND will be responsible for all charges in excess of the UCR as described herein.
Emergency Services	All of the following with respect to an Emergency Medical Condition: • A medical screening examination (as required under the Emergency Medical Treatment and Active Labor Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition • Within the capabilities of the staff and facilities available at the hospital, the further medical examination and treatment that the Emergency Medical Treatment and Active Labor Act requires to Stabilize the patient
Emergency Medical Condition	A medical or psychiatric condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: • Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy • Serious impairment to bodily functions • Serious dysfunction of any bodily organ or part
ERISA	The Employee Retirement Income Security Act of 1974, as amended.
Family	A Member and all of his or her Dependents.
HIPAA	The Health Insurance Portability and Accountability Act, as amended.
Hospice	A specialized form of interdisciplinary health care designed to provide palliative care and to alleviate the physical, emotional, and spiritual discomforts you may experience during the last phases of life due to a terminal illness. It also provides support to your primary caregiver and your family.

Term	Definition
Kaiser Permanente	A Network of Providers that operate through Regions, each of which has a Service Area. For each Kaiser Permanente Region, Kaiser Permanente consists of Kaiser Foundation Hospitals (a California nonprofit corporation) and the Medical Group for that Region: • Kaiser Foundation Health Plan, Inc., for the Northern California Region the Southern California Region, and the Hawaii Region • Kaiser Foundation Health Plan of Colorado for the Colorado Region • Kaiser Foundation Health Plan of Georgia, Inc., for the Georgia Region • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., for the Mid-Atlantic States Region • Kaiser Foundation Health Plan of the Northwest for the Northwest Region • Kaiser Foundation Health Plan of Ohio for the Ohio Region
KPIC	Kaiser Permanente Insurance Company, which provides claims administrative services.
Medically Necessary	A Service is Medically Necessary if, in the judgment of the Program, it meets all of the following requirements: • It is required for the prevention, diagnosis, or treatment of your medical condition • Omission of the Service would adversely affect your condition • It is provided in the least costly medically appropriate setting • It is in accord with generally accepted professional standards of practice that is consistent with a standard of care in the medical community.
Medicare	A federal health insurance program for people age 65 and older, certain people with disabilities or end-stage renal disease (ESRD).
Member	A person who is enrolled in the Program if that person is eligible in his own right and not because if his or her relationship to someone else. This Summary sometimes refers to a Dependent or Member as “you.”

Term	Definition
Network Provider	A Network Hospital, Physician, Pharmacy, Skilled Nursing Facility, Medical Group, or any other health care provider under contract with Kaiser Permanente to provide Covered Services. Network Providers are subject to change at any time without notice. For current locations of Network facilities please call Customer Service at the number listed in the "Customer Service Phone Numbers" section. To find a Kaiser Pharmacy visit www.kp.org - select the Locate Our Services tab, select your region, and then select the Facilities tab. **Network Facility** Any facility listed in Welcome to Your Plan or on kp.org. Note: Facilities are subject to change at any time, for the current locations, call Customer Service. **Network Hospital** A licensed hospital owned and operated by Kaiser Foundation Hospitals or another hospital which contracts with Kaiser Foundation Hospitals to provide Covered Services. **Network Pharmacy** A pharmacy owned and operated by Kaiser Permanente, or another pharmacy that Kaiser Permanente designates. **Network Physician** A licensed physician who is a partner, shareholder, or employee of the Medical Group, or another licensed physician who contracts with the Medical Group to provide Covered Services. • Medical Group: The following medical group is available for Northern California members: ○ The Permanente Medical Group for the Northern California Region • The Southern California Permanente Medical Group for the Southern California Region • Colorado Permanente Medical Group, P.C., for the Colorado Region • The Southeast Permanente Medical Group, Inc., for the Georgia Region • Hawaii Permanente Medical Group, Inc., for the Hawaii Region • Mid-Atlantic Permanente Medical Group, P.C., for the Mid-Atlantic States Region • Northwest Permanente, P.C., Physicians & Surgeons, for the Northwest Region • Ohio Permanente Medical Group, Inc., for the Ohio Region **Network Skilled Nursing Facility** A licensed facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services that contracts with Kaiser Permanente to provide Covered Services. The facility's primary business is the provision of 24-hour-a-day skilled nursing care. The term "Skilled Nursing Facility" does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A "Skilled Nursing Facility" may also be a unit or section within another facility as long as it continues to meet the definition.
Non-Network Provider or Out-of-Network Provider	Any licensed provider that is not a Network Provider who provides Covered Services.
Out-of-Pocket Maximum	Your financial responsibility for covered medical expenses before the Program reimburses additional Eligible Charges at 100%, with no Deductible, for the remaining portion of that calendar year.

Term	Definition
Plan Administrator	Sandia National Laboratories
Plan Sponsor	The plan sponsor named in the Sandia Total Health Plan Document
Post-Stabilization Care	Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that your condition is Clinically Stable.
Primary Care	Care provided by a Network Provider who specializes in internal medicine, pediatrics or family practice Services.
Prior Authorization	Medical Necessity approval obtained in advance which is required for certain services to be Covered Services under the Program. Authorization is not a guarantee of payment and will not result in payment for services that do not meet the conditions for payment by the Program.
Program	Part of the plan named in the Sandia Total Health Plan Document
Prosthetics and Orthotics	An external prosthetic device is a device that is located outside of the body which replaces all or a portion of a body part or that replaces all or portion of the function of a permanently inoperative or malfunctioning body part. Internally implanted prosthetic devices are devices placed inside the body through a surgical incision which replaces all or a portion of a body part or that replaces all or portion of the function of a permanently inoperative or malfunctioning body part Orthotics are rigid or semi-rigid external devices that are used for the purpose of supporting a weak or deformed body part, improving the function of moveable parts or for restricting or eliminating motion in a diseased or injured part of the body.
Reconstructive Surgery	Surgery is to improve function and under certain conditions, to restore normal appearance after significant disfigurement.
Region	A geographic area serviced by Kaiser Permanente. See “Kaiser Permanente” in this “Definitions” section.
Services	Healthcare, including mental health care, services and items.
Service Area	A smaller geographic area of a Kaiser Permanente Region.
Specialty Care	Care provided by a Network Provider or Non-Network Provider who provides Services other than Primary Care Services.
Stabilize	To provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), “Stabilize” means to deliver (including the placenta).
Urgent Care	Treatment of an unexpected Sickness or Injury that is not life threatening but requires Outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering such as high fever, a skin rash, or an ear infection.

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Section 11. General Exclusions and General Limitations

The Services listed in this section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered.

Before coverage begins-Any services, drugs, or supplies you receive while you are not enrolled in this Plan.

- Behavioral/Conduct Problems — educational services and programs or therapies for behavioral/conduct problems.
- Conduct disturbances unless related to a coexisting condition or diagnosis otherwise covered.
- Educational, vocational, and/or recreational services as outpatient procedures.
- Biofeedback
- Treatment for insomnia, other sleep disorders, dementia, neurological disorders, and other disorders with a known physical basis (certain treatments may be covered under medical portion of the Program).
- Court-ordered placements when such orders are inconsistent with the recommendations for treatment.
- Services to treat conditions that are identified by the most current edition of the Diagnostic and Statistical Manual of Mental Disorders as not being attributable to a Mental Disorder.
- Sex transformations.
- Any services or supplies that are not Medically Necessary.
- Custodial Care, Pastoral counseling.
- Developmental Care.
- Treatment for caffeine or tobacco addictions, withdrawal, or dependence. This does not include classes available through your Network Facility.
- Aversion therapies.
- Treatment for codependency.
- Non-abstinence-based or nutritionally-based treatment for substance abuse.
- Services, supplies, or treatments that are Covered Services under the medical part of this Program.
- Treatment or consultations provided via telephone.
- Services, treatments, or supplies provided as a result of a Workers' Compensation law or similar legislation, or obtained through, or required by, any government agency or program, whether federal, state, or any subdivision, or caused by the conduct or omission of a third party for which you have a claim for damages or relief.

- Non-organic 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 the Program.
- Services or supplies that:
    - Are considered Unproven, Experimental or Investigational drugs, devices, treatments, or procedures.
    - Result from or relate to the application of such Experimental or Investigational drugs, devices, treatments, or procedures.
- Wilderness programs, boot camp-type programs, work camp-type programs, or recreational-type programs.
- Services or supplies that are primarily for your education, training, or development of skills needed to cope with an Injury or Sickness.
- Substance Abuse benefits for Class II dependents.
- Blood — The cost of whole red blood or red blood cells when they are donated or replaced or billed, except expenses for administration and processing of Blood and Blood Products (except Blood Factors) covered as part of inpatient and outpatient services.
- Biofeedback.
- (Behavioral) Mental Health and Substance Abuse Service Exclusion:
    - Treatment for learning disabilities and pervasive Developmental Disorders (including autism) other than diagnostic evaluation.
- Chiropractic Exclusions:
    - Services for conditions other than Neuromusculoskeletal Disorders
    - Behavior training and sleep therapy
    - Thermography
    - Any radiologic exam, other than plain film studies, such as magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), bone scans and nuclear radiology
    - Non-medical self-care or self-help, any self-help physical exercise training, and any related diagnostic testing
    - Services for vocational rehabilitation
    - Air conditioners, air purifiers, therapeutic mattresses; chiropractic appliances, supplies and devices.
    - Hospital Services, anesthesia, manipulation under anesthesia, and related Services
    - Adjunctive therapy not associated with spinal, muscle, or joint manipulations Vitamins, minerals, nutritional supplements, and similar products.

- Cosmetic services — Except as otherwise specified for services covered under Reconstructive Surgery.
- Crime — Treatment of injuries sustained while committing a crime.
- Custodial care means assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine), or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. This exclusion does not apply to Services covered under "Hospice Care".
- Dental coverage will not be provided for extractions, treatment of cavities, care of the gums or bones structures directly supporting the teeth. Structures supporting the teeth mean the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth, and alveolar process, treatment of periodontal abscess, removal of impacted teeth, orthodontia (including braces), false teeth, or any other dental services or supplies, except as otherwise covered under this Summary Plan Description (SPD). This exclusion does not apply to accidental injury to sound and natural teeth. See other section for covered services.
- Dental procedures and appliances to correct disorders of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders).
- Equipment — that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for you or your Dependent, i.e., exercycle or other physical fitness equipment, elevators, hoyer lifts, shower/bath bench. Air conditioners, air purifiers and filters, batteries and charges, dehumidifiers, humidifiers, air cleaners and dust collection devices.
- Education — Coverage does not include services other than self management of a medical condition as determined by the Health Plan to be primarily educational in nature.
- Experimental or investigational Services — A Service is experimental or investigational if the Healthplan, in consultation with Medical Group, determine that generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients):
    - It requires government approval that has not been obtained when Service is to be provided; It requires government approval that has not been obtained when Service is to be provided;
    - It cannot be legally performed or marketed in the United States without FDA approval;
    - It is the subject of a current new drug or device application on file with the FDA;
    - It is provided as part of a research trial; see specific section for Clinical Trials;
    - It is provided pursuant to a written protocol or other document that lists an evaluation of the service’s safety, toxicity or efficacy as among its objectives;
    - It is subject to approval or review of an Institutional Review Board or other body that approves or reviews research;

    - It is provided pursuant to informed consent documents that describe the services as experimental or investigational, or indicate that the services are being evaluated for their safety, toxicity or efficacy; or
    - The prevailing opinion among experts is that use of the services should be substantially confined to research settings or further research is necessary to determine the safety, toxicity or efficacy of the service.
- Foot care — except when Medically Necessary.
- Genetic Testing — Experimental or investigational genetic testing is not covered.
- Government Programs — Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Participant had applied for such benefits. Services that can be provided through a government program for which you as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
- Hypnotherapy (Hypnosis).
- Massage Therapy except when provided as a procedure during a covered therapy.
- Medical Reports — Completion of specific medical reports, including those not directly related to treatment of the Participant, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
- Medical supplies — Disposable Supplies for Home Use.
- Membership costs or fees associated with health clubs, weight loss programs.
- Nutritional supplements and formulae except for formula needed for the treatment of inborn errors of metabolism.
- Obesity — Weight reduction programs: Fees and charges relating to fitness programs, weight loss or weight control programs.
- Personal Comfort Items — Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, hospital admission kit, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, over the counter convenience items and take-home supplies.
- Pharmacy Exclusions — If a Service is not covered under this Summary, any drugs or supplies needed in connection with that Service are not covered:
    - Compounded products unless the drug is listed on the drug formulary or one of the ingredients requires a prescription by law
    - Drugs used to enhance athletic performance
    - Drugs that are not approved by the Federal Drug Administration
    - Experimental or Investigational Drugs
    - Drugs prescribed for cosmetic purposes
    - Replacement of lost, damaged or stolen drugs

- Drugs that shorten the duration of the common cold
- Special packaging — Packaging of prescription medications is limited to Kaiser Permanente standard packaging
- Drugs which are available over the counter and prescriptions for which drug strength may be realized by the over the counter product
- Drugs for which there is an over the counter equivalent unless it is covered under Preventive Medications.

- Physical examinations and other Services, and related reports and paperwork, in connection with third-party requests or requirements, such as those for: employment, participation in employee programs, insurance, disability, licensing, or on court order or for parole or probation.
- Private Duty Nursing as a registered bed patient unless a Plan physician determines medical necessity.
- Private Duty Nursing in home or long term facility.
- Private room unless medically necessary or if a semi-private room is not available.
- Provider (Close Relative) — Services rendered by a Provider who is a close relative or member of your household. Close relative means wife or husband, parent, child, brother or sister, by blood, marriage or adoption.
- Recreational, diversional and play activities.
- Related services to a non covered service — All services, drugs, or supplies related to the non-covered service are excluded from coverage, except services we would otherwise cover to treat complications of the non-covered service.
- Religious, personal growth counseling or marriage counseling including services and treatment related to religious, personal growth counseling or marriage counseling unless the primary patient has a DSM IV diagnosis.
- Respite Care is listed as an exclusion for all Sandia plans. However, this exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under *Hospice Care.*
- Services, drugs, or supplies not required to prevent, diagnose, or treat a medical condition.
- Services provided outside the United States-Services, other than Emergency Services, received outside the United States whether or not the Services are available in the United States.
- Sexual reassignment-all services related to sexual reassignment.
- Shoes — Shoe inserts, orthotics (except for care of the diabetic foot).

- Surrogate. Services related to conception, pregnancy or delivery in connection with a surrogate arrangement. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. In situations where you receive monetary compensation to act as a surrogate, Health Plan will seek reimbursement of all Charges for Covered Services you receive that are associated with conception, pregnancy and/or delivery of the child. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.
- Testing for ability, aptitude, intelligence or interest.
- Transplant:
    - Out-of-Network transport and lodging is excluded
    - Organ/tissue transplants which are experimental or investigational are not covered
    - Non-human and artificial organs and their implantation are not covered
    - Travel or transportation (other than a state licensed Professional Ambulance Service) expenses even though prescribed by a Physician except as noted under Transplants.
- Usual, Customary and Reasonable Fees — Expenses in excess of Usual, Customary and Reasonable Fees.
- Vision (Surgical Correction) — Radial keratotomy; and surgery, services, evaluations or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
- Vision — Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) or visual training.
- Vision-medical benefits for low vision aids, eyeglasses, contact lenses for prescription or fitting and follow-up care thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows cataract.
- Waived fees — Free Care (no charge items).
- War — Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service provided or available from the Veterans' Administration or military medical facilities as required by law.
- Workers' Compensation — Care for any condition or Injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law. Exception: Benefits are provided for actively employed partners and small business owners not covered under a Workers' Compensation Act or similar law, if elected by the Group and additional Premium is paid.
- Services or supplies for injuries or diseases related to you or your Dependent's job to the extent you or your Dependent is required to be covered by a workers' compensation law.

Section 12. Coordination of Benefits (COB)

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

Refer to the *Sandia Health Benefits Plan for Employees Summary Plan Description* or the *Sandia Health Benefits Plan for Retirees Summary Plan Description* for more information on COB policy and rules for determining which plan provides primary coverage.

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

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

- If a covered person is confined in a private hospital room, the difference between the cost of a semi-private hospital room and the private room (unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice, or one of the group health plans routinely provides coverage for hospital private rooms) is not a Covered Health Expense.

- If a person is covered by two or more group health plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest of the usual and customary fees (or other reimbursement amount) for a specific benefit is not a Covered Health Expense.

- If a person is covered by two or more group health plans that provide benefits or Services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not a Covered Health Expense.

- If a person is covered by one group health plan that calculates its benefits or Services on the basis of usual and customary fees and another group health plan that provides its benefits or Services on the basis of negotiated fees, the primary plan's payment arrangements shall be the Covered Health Expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or Service for a payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Covered Health Expense used by the secondary plan to determine its benefits.

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

Refer to Section 3 of the *Sandia Health Benefits Plan for Employees Summary Plan Description* or the *Sandia Health Benefits Plan for Retirees Summary Plan Description* for more information on "Special Rules for Covered Medicare-Primary Members" and "Provision for Covered Members with End-Stage Renal Disease (ESRD)."

Beginning January 1 of every year or if you are a new enrollee, you are required to provide an update to Kaiser Permanente on whether any of your covered family members have other insurance. This notification is also required if your family member enrolls in another medical plan during the year. If you do not provide this information to Kaiser Permanente, your covered family members' claims may be denied. You may update your other insurance information by calling Kaiser Permanent at 800-663-1771.

Refer to Section 8, Prescription Drug Program for information on eligibility to use the Prescription Drug Program, as well as how COB works, if your covered family member has other insurance coverage.

Section 13. Binding Arbitration

Binding Arbitration for Members and Dependents Assigned to the Kaiser Permanente Northern California Region

This "Binding Arbitration for Members and Dependents Assigned to the Kaiser Permanente Northern California Region" section applies only to Members and Dependents who are assigned to the Kaiser Permanente Northern California Region.

For all claims subject to this "Binding Arbitration for Members and Dependents Assigned to the Kaiser Permanente Northern California Region" section, both Claimants and Respondents give up the right to a jury or court trial and accept the use of binding arbitration.

Scope of Arbitration

Any dispute shall be submitted to binding arbitration if all of the following requirements are met:

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to a Member or Dependent Party's relationship to Kaiser Permanente or KPIC as a Member or Dependent, a member, or a patient, including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the delivery of services or items, irrespective of the legal theories upon which the claim is asserted
- The claim is asserted by one or more Member or Dependent Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member or Dependent Parties
- The claim is not within the jurisdiction of the Small Claims Court
- The claim is not a benefit-related request that constitutes a "benefit claim" in Section 502(a)(1)(B) of ERISA

As referred to in this "Binding Arbitration for Members and Dependents Assigned to the Kaiser Permanente Northern California Region" section, "Member or Dependent Parties" include:

- A Member or Dependent
- A Member's or Dependent's heir, relative, or personal representative
- Any person claiming that a duty to him or her arises from a Member's or Dependent's relationship to one or more Kaiser Permanente Parties

"Kaiser Permanente Parties" include:

- Kaiser Permanente Insurance Company (KPIC)
- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals (KFH)
- KP Cal, LLC (KP Cal)

- The Permanente Medical Group, Inc. (TPMG)
- Southern California Permanente Medical Group (SCPMG)
- The Permanente Federation, LLC
- The Permanente Company, LLC
- Any KFH, TPMG, or SCPMG physician
- Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Member or Dependent Parties
- Any employee or agent of any of the foregoing

"Claimant" refers to a Member or Dependent Party or a Kaiser Permanente Party who asserts a claim as described above. "Respondent" refers to a Member or Dependent Party or a Kaiser Permanente Party against whom a claim is asserted.

Initiating Arbitration

Claimants shall initiate arbitration by serving a Demand for Arbitration. The Demand for Arbitration shall include the basis of the claim against the Respondents; the amount of damages the Claimants seek in the arbitration; the names, addresses, and telephone numbers of the Claimants and their attorney, if any; and the names of all Respondents. Claimants shall include all claims against Respondents that are based on the same incident, transaction, or related circumstances in the Demand for Arbitration.

Serving Demand for Arbitration

KPIC, Kaiser Foundation Health Plan, Inc., KFH, KP Cal, TPMG, SCPMG, The Permanente Federation, LLC, and The Permanente Company, LLC, shall be served with a Demand for Arbitration by mailing the Demand for Arbitration addressed to that Respondent in care of one of the following:

- If the claim relates to a Member or Dependent who is assigned to the Kaiser Permanente Northern California Region:

  Kaiser Foundation Health Plan, Inc.
  Legal Department
  1950 Franklin St., 17th Floor
  Oakland, CA 94612

- If the claim relates to a Member or Dependent who is assigned to the Kaiser Permanente Southern California Region:

  Kaiser Foundation Health Plan, Inc.
  Legal Department
  393 E. Walnut St.
  Pasadena, CA 91188

Service on that Respondent shall be deemed completed when received. All other Respondents, including individuals, must be served as required by the California Code of Civil Procedure for a civil action.

Filing Fee

The Claimants shall pay a single, nonrefundable filing fee of $150 per arbitration payable to "Arbitration Account" regardless of the number of claims asserted in the Demand for Arbitration or the number of Claimants or Respondents named in the Demand for Arbitration.

Any Claimant who claims extreme hardship may request that the Office of the Independent Administrator waive the filing fee and the neutral arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Office of the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling Customer Service at the telephone number listed on your ID card.

Number of Arbitrators

The number of Arbitrators may affect the Claimant's responsibility for paying the neutral arbitrator's fees and expenses.

If the Demand for Arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one neutral arbitrator, unless the parties otherwise agree in writing that the arbitration shall be heard by two party arbitrators and one neutral arbitrator. The neutral arbitrator shall not have authority to award monetary damages that are greater than $200,000.

If the Demand for Arbitration seeks total damages of more than $200,000, the dispute shall be heard and determined by one neutral arbitrator and two party arbitrators, one jointly appointed by all Claimants and one jointly appointed by all Respondents. Parties who are entitled to select a party arbitrator may agree to waive this right. If all parties agree, these arbitrations will be heard by a single neutral arbitrator.

Payment of Arbitrators' Fees and Expenses

Kaiser Foundation Health Plan, Inc. will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* ("Rules of Procedure"). In all other arbitrations, the fees and expenses of the neutral arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

If the parties select party arbitrators, Claimants shall be responsible for paying the fees and expenses of their party arbitrator and Respondents shall be responsible for paying the fees and expenses of their party arbitrator.

Costs

Except for the aforementioned fees and expenses of the neutral arbitrator, and except as otherwise mandated by laws that apply to arbitrations under this “Binding Arbitration for Members and Dependents Assigned to the Kaiser Permanente Northern California Region” section, each party shall bear the party's own attorneys' fees, witness fees, and other expenses incurred in prosecuting or defending against a claim regardless of the nature of the claim or outcome of the arbitration.

Rules of Procedure

Arbitrations shall be conducted according to the Rules of Procedure developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from Customer Service at the telephone number listed in the "Customer Service Phone Numbers".

General Provisions

A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondents served by the applicable statute of limitations, (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (a) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the neutral arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for non-economic losses, and the right to have an award for future damages conformed to periodic payments, shall apply to any claims for professional negligence or any other claims as permitted or required by law.

Arbitrations shall be governed by this "Binding Arbitration for Members and Dependents Assigned to the Kaiser Permanente Northern California Region" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this "Binding Arbitration for Members and Dependents Assigned to the Kaiser Permanente Northern California Region" section.

In accord with the rule that applies under sections 3 and 4 of the Federal Arbitration Act, the right to arbitration under this "Binding Arbitration for Members and Dependents Assigned to the Kaiser Permanente Northern California Region" section shall not be denied, stayed, or otherwise impeded because a dispute between a Member or Dependent Party and a Kaiser Permanente Party involves both arbitrable and nonarbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with a third party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

Section 14. Claims and Appeals

To obtain payment from the Program when for Services you have paid for or to obtain review of a claims payment decision, you must follow the procedures outlined in this "Claims and Appeals" section. You may appoint an authorized representative to help you file your claim or appeal. A written authorization must be received from you before any information will be communicated to your representative.

If you miss a deadline for filing a claim or appeal, review may be declined. Before you can file a civil action under ERISA section 502(a)(1)(B), you must meet any deadlines and exhaust the claims and appeals procedures set forth in this "Claims and Appeals" section. The Program does not charge you for claims or appeals, but you must bear the cost of anyone you hire to represent or help you.

How to File a Claim

Network Providers are responsible for submitting claims for their services on your behalf and will be paid directly by the Program for the services they render. If a Network Provider bills you for a Covered Service (other than for Cost Sharing), please call customer service at the telephone number listed in the "Customer Service Phone Numbers" section.

For services rendered by Non-Network providers, where the provider agrees to submit a claim on your behalf, eligible claims payment to the provider will require a valid assignment of benefits. Even if the Non-Network Provider agrees to bill on your behalf, you are responsible for making sure that the claim is received within 365 days of the date of service and that all information necessary to process the claim is received.

To receive reimbursement for Services you have paid for, you must complete and mail a claim form or (or write a letter) to the Claims Administrator at the address listed in the "Customer Service Phone Numbers" section, within 365 days after you receive Services. The claim form (or letter) must explain the Services, the date(s) you received Services, where you received Services, who provided Services, and why you think the Program should pay for Services. Include a copy of the bill and any supporting documents. Your claim form (or letter) and the related documents constitute your claim.

IMPORTANT: All claims must be submitted within one year from the date of service in order to be eligible for consideration of payment. This one-year requirement will not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends. It is recommended that claims be submitted as soon as possible after the medical or prescription expenses are incurred. HRA funds will be rolled-over to the subsequent calendar year after 90 days from the end of the plan year; therefore, if you file a claim, for example, in May of 2012 for 2011 services, HRA funds will not be available to pay that claim. If you need assistance in filing a claim, call Kaiser General Member Service at 1-800-663-1771.

Your claim must include all of the following information:

- Patient name, address, and Kaiser Permanente ID card medical or health record number
- Date(s) of service
- Diagnosis
- Procedure codes and description of the Services
- Charges for each Service
- The name, address, and tax identification number of the provider
- The date the injury or illness began
- Any information regarding other medical coverage

To obtain a medical or pharmacy claim form, visit www.kp.org, log in, and then go to My Health Manager then My Medical Record. The claim form will inform you about other information that you must include with your claim.

If the Program pays a Post-Service Claim, it will pay you directly, except that it will pay the provider if one of the following is true:

- Before the claim is processed, a written notice is received indicating you have assigned your right to payment to the provider
- Your claim includes a written request that the Program pay the provider

If you have any questions about submitting a claim for payment for a Service from a Non-Network Provider, please call customer service at the telephone number listed on your ID card or in the "Customer Service Phone Numbers" section.

Timing of Claim Determinations

The Program adheres to certain time limits when processing claims for benefits. If you do not follow the proper procedures for submitting a claim, the Program will notify you of the proper procedures within the time frames shown in the chart below. If additional information is needed to process your claim, the Program will notify you within the time frames shown in the chart below, and you shall be provided additional time within which to provide the requested information as indicated in the chart below in this "Timing of Claim Determinations" section.

Program will make a determination on your claim within the time frames indicated below based upon the type of claim: Urgent Claim, Pre-Service Claim, Post-Service Claim, or Concurrent Care Claim.

An "Urgent Care Claim" is any claim for a Service with respect to which the application of the time periods for making non-urgent care determinations either (a) could seriously jeopardize your life, health, or ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services that are the subject of the claim.

A "Pre-Service Claim" is any claim for a Service with respect to which the terms of Program condition receipt of the Service, in whole or in part, on approval by Program of the Service in advance.

A "Post-Service Claim" is any claim for a Service that is not a Pre-Service Claim or an Urgent Care Claim.

A "Concurrent Care Claim" is any claim for Services that are part of an on-going course of treatment that was previously approved by Program for a specific period of time or number of treatments.

Type of Notice or Claim Event	Urgent Care Claim	Pre-Service Care Claim	Post-Service Care Claim
The Program Notice of Failure to Follow the Proper Procedure to File a Claim	Not later than 24 hours after receiving the improper claim.	Not later than 5 days after receiving the improper claim.	Not applicable.
The Program Notice of Initial Claim Decision	If the claim when initially filed is proper and complete, a decision will be made as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receiving the initial claim. If the claim is not complete, The Program shall notify you as soon as possible, but not later than 24 hours of receipt of the claim. You shall have 48 hours to provide the information necessary to complete the claim. A decision will be made not later than 48 hours after the administrator receives the requested information, or within 48 hours after the expiration of the 48-hour deadline for submitting additional information, whichever is earlier.	If the claim when initially filed is proper and complete, a decision will be made within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the initial claim is received, unless an extension, of up to 15 days, is necessary due to matters beyond the control of The Program You shall be notified within the initial 15 days if an extension will be needed by The Program. The notice shall state the reason for the extension. A decision will be made not later than 15 days after the initial claim is received, unless additional information is required from you. You will be notified during the initial 15 day period, and shall have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving the additional information, or within 15 days after the expiration of the 45-day deadline for submitting additional information, which-ever is earlier.	A decision will be made within a reasonable amount of time, but not later than 30 days after the initial claim is received, unless an extension, of up to 15 days, is necessary due to matters beyond the control The Program. You shall be notified within the initial 30 days if an extension will be needed by The Program. The notice shall state the reason for the extension. A decision will be made not later than 30 days after the initial claim is received, unless additional information is required from you. You will be notified during the initial 30 day period, and shall have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving the additional information or, within 15 days after the expiration of the 45-day deadline for submitting additional information, whichever is earlier.

If you have a Concurrent Care Claim that is also an Urgent Care Claim to extend a previously approved on-going course of treatment provided over a period of time or number of treatments, the Program will make a determination as soon as possible, taking into account the medical exigencies, and notify you of the determination within twenty-four (24) hours after receipt of the claim, provided that the claim was made to the Program at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments previously approved. If your request for extended treatment is not made at least twenty-four (24) hours prior to the end of the prescribed period of time or number of treatments, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

If your Concurrent Care Claim is not an Urgent Care Claim, and there is a reduction or termination of the previously approved on-going course of treatment provided over a period of time or number of treatments (other than by the Program amendment or termination) before the end of the period of time or number of treatments, you will be notified by the Program sufficiently in advance of the reduction or termination to allow you to appeal the denial and receive a determination on appeal before the reduction or termination of the benefit.

If a Claim Is Denied

If all or part of your claim is denied, the Program will send you a written notice. If the notice of denial involves an Urgent Care Claim, the notice may be provided orally (a written or electronic confirmation will follow within 3 days). This notice will explain:

- The reasons for the denial, including references to specific the Program provisions upon which the denial was based.
- If the claim was denied because you did not furnish complete information or documentation, the notice will specify the additional materials or information needed to support the claim and an explanation of why the information or materials are necessary.
- If the claim is denied based on an internal rule, guideline, protocol, or other similar criterion, the notice will either (a) state the specific rule, guideline, protocol, or other similar criterion, or (b) or include a statement that the rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge upon request.
- If the claim is denied based on a medical necessity or experimental treatment or a similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Program to the medical circumstances, or include a statement that this explanation will be provided free of charge upon request.
- The notice will also state how and when to request a review of the denied claim.
- The notice will also contain a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination following completion of all levels of review.

How to Appeal a Denied Claim

You may appeal a denied claim by submitting a written request for review to the Program. You must make the appeal request within 180 days after the date of the denial notice. Send the written request to the Program at:

Kaiser Permanente Insurance Company – Appeals
3701 Boardman-Canfield Road
Canfield, Ohio 44406

You may instead fax your appeal to 614-212-7110.

To appeal a pharmacy claim, submit your form to:

Kaiser Permanente
Attn: SFAS National Self Funding
38990 Murphy Canyon Rd Suite 200
San Diego, CA 92123
Fax# 858-614-7912

The request must explain why you believe a review is in order and it must include supporting facts and any other pertinent information. The Program may require you to submit such additional facts, documents, or other material as it may deem necessary or appropriate in making its review.

Procedures on Appeal

As part of the review procedure, you may submit written comments, documents, records, and other information relating to the claim.

Upon request and free of charge, you will be provided reasonable access to, and copies of, all documents, records, and other information (other than legally or medically privileged documents) relevant to your claim.

the Program will review the claim, taking into account all comments, documents, records, and other information submitted relating to the claim, without regard to whether that information was submitted or considered in the initial benefit determination.

The review shall not afford deference to the initial claim denial and shall be conducted by the Claims Fiduciary (named in the "Legal and Administrative Information" section), who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of that individual.

In deciding an appeal that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary, the Claims Fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and that health care professional shall not be the individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal (nor the subordinate of that individual).

Upon request, the Program will provide for the identification of any medical or vocational experts whose advice was obtained on behalf of the Program in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Timing of Initial Appeal Determinations

The Program will act upon each request for a review within the time frames indicated in the chart below:

Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Not later than 72 hours after receiving the appeal.	Not later than 15 days after receiving the appeal	Not later than 30 days after receiving the appeal.

Notice of Determination on Initial Appeal

Within the time prescribed in the "Timing of Initial Appeal Determinations" section, the Program will provide you with written notice of its decision. If the Program determines that benefits should have been paid, the Program will take whatever action is necessary to pay them as soon as possible.

If your claim is denied on review, the notice shall state:

- The reasons for the denial, including references to specific the Program provisions upon which the denial was based.
- That you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (other than legally or medically privileged documents) relevant to your claim.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the notice will either (a) state the specific rule, guideline, protocol, or other similar criterion, or (b) include a statement that the rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge upon request.
- If the claim is denied based on a Medical Necessity, Experimental, or similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Program to the medical circumstances, or include a statement that such explanation will be provided free of charge upon request.
- For Pre-Service Claims and Post-Service Claims, the notice will also state how and when to request a review of the denial of the initial appeal.
- For Urgent Care Claims, the notice will also describe any voluntary appeal procedures offered by the Program and your right to obtain the information about those procedures.
- The notice will also include a statement of your right to bring an action under section 502(a) of ERISA following an adverse benefit determination following completion of all levels of review.

How to File a Final Appeal

For Pre-Service Claims and Post-Service Claims, you may appeal the denial of your initial appeal by submitting a written request for review to the Plan. You must make the appeal request within 60 days after the date of notice that your appeal is denied.

Send the written request to:

Kaiser Permanente Insurance Company – Appeals
3701 Boardman-Canfield Road
Canfield Ohio 44406

Or fax your appeal to 614-212-7110

To appeal a pharmacy claim, submit your form to:

Kaiser Permanente
Attn: SFAS National Self Funding
38490 Murphy Canyon Rd Suite 200
San Diego, CA 92123

Or fax your appeal to 858-614-7912

Timing of Final Appeal Determinations

For Pre-Service Claims and Post-Service Claims, the Program will act upon each request for a review of the denial of your initial appeal within the time frames indicated in the chart below:

Pre-Service Claim	Post-Service Claim
Not later than 15 days after the appeal is received.	Not later than 30 days after the appeal is received.

Notice of Determination on Final Appeal

Within the time prescribed in the "Timing of Final Appeal Determinations" section, the Program will provide you with written notice of its decision. If the Program determines that benefits should have been paid, the Program will take whatever action is necessary to pay them as soon as possible.

If your claim is denied on review, the notice shall state:

- The reasons for the denial, including references to specific the Program provisions upon which the denial was based.
- That you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (other than legally or medically privileged documents) relevant to your claim for benefits.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the notice will either (a) state the specific rule, guideline, protocol, or other similar criterion, or (b) include a statement that the rule, guideline, protocol, or other

similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge upon request.

- If the claim is denied based on a Medical Necessity, Experimental treatment or similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Program to the medical circumstances, or include a statement that this explanation will be provided free of charge upon request.
- Any voluntary appeal procedures offered by the Program and your right to obtain the information about those procedures.
- The notice will also include a statement of your right to bring an action under section 502(a) of ERISA following an adverse benefit determination following completion of all levels of review.

Section 15. Services that Require Prior Authorization

Services not available from Network Providers. If your Network Physician decides that you require Covered Services not available from Network Providers, he or she will recommend to the Medical Group that you be referred to a Non–Network Provider inside or outside the Service Area. The appropriate Medical Group designee will Authorize the Services if he or she determines that they are Medically Necessary and are not available from a Network Provider. Referrals to Non– Network Physicians will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. Please ask your Network Physician what Services have been Authorized.

- Durable medical equipment (DME). If your Network Physician prescribes a DME item, he or she will submit a written referral to the Network Hospital's DME coordinator, who will Authorize the DME item if he or she determines that your DME coverage includes the item and that the item is listed on the Kaiser Permanente DME formulary for your condition. If the item doesn't appear to meet the Plan's DME formulary guidelines, then the DME coordinator will contact the Network Physician for additional information. If the DME request still doesn't appear to meet the Kaiser Permanente's DME formulary guidelines, it will be submitted to the Medical Group's designee Network Physician, who will Authorize the item if he or she determines that it is Medically Necessary.

For more information about the Kaiser Permanente's DME formulary, please refer to "Durable Medical Equipment (DME), External Prosthetics and Orthotics" in the "Benefits and Cost Sharing" section.

- Ostomy and urological supplies. If your Network Physician prescribes ostomy or urological supplies, he or she will submit a written referral to the Network Hospital's designated coordinator, who will Authorize the item if he or she determines that it is covered and the item is listed on the Kaiser Permanente's soft goods formulary for your condition. If the item doesn't appear to meet the Kaiser Permanente's soft goods formulary guidelines, then the coordinator will contact the Network Physician for additional information. If the request still doesn't appear to meet the Kaiser Permanente's soft goods formulary guidelines, it will be submitted to the Medical Group's designee Network Physician, who will Authorize the item if he or she determines that it is Medically Necessary. For more information about the Kaiser Permanente's soft goods formulary, please refer to "Ostomy and Urological Supplies" in the "Benefits and Cost Sharing" section
- Transplants. If your Network Physician makes a written referral for a transplant, the Medical Group's Regional transplant advisory committee or board (if one exists) will Authorize the Services if it determines that they are Medically Necessary. In cases where no transplant committee or board exists, the Medical Group will refer you to physician(s) at a transplant center, and the Medical Group will Authorize the Services if the transplant center's physician(s) determine that they are Medically Necessary.

Note: A Network Physician may provide or Authorize a corneal transplant without using this Medical Group transplant Authorization procedure.

Decisions regarding requests for Authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

- Cosmetic and plastic surgery when specifically under the "Reconstructive Surgery" section
- Drug formulary exceptions
- Durable medical equipment
- Hospice and home health Services
- Inpatient hospital Services
- Non-emergency medical transportation
- Open MRI
- Orthognathic surgery
- Referrals for non-Network Provider Services
- Rehabilitative Therapy Services
- Routine foot Services
- Skilled Nursing Facility Services
- Transplant Services

For more information about utilization review, a copy of the complete utilization review criteria approved by the Program for a specific condition, or to talk to a utilization review staff person, please contacts customer service. Please refer to the customer service numbers for your home Region in the Customer Service Phone Numbers section.

Except in the case of misrepresentation, Prior Authorization determinations that relate to your Eligibility are binding if obtained no more than five business days before you receive the Service. Prior Authorization determinations that relate to whether the Service is Medically Necessary or are covered under the Program are binding if obtained no more than 30 days before you receive the Service. Authorizations for Services may be revoked or amended if you have not yet received the services, if your participation terminates or your coverage changes or you lose your Eligibility.

All inpatient hospital admissions and services (this does not apply to emergency admissions), inpatient mental health and chemical dependency services

- Inpatient rehabilitation therapy services or programs
- Apligraf
- Certain Ambulatory and outpatient Surgeries
- Bariatric Surgery (all visits and procedures)
- Biventricular pacemaker
- Blepharoplasty
- Breast augmentation
- Breast reduction

- Circumcision (pediatric and adult)
- Cosmetic procedures (any procedure that could be considered cosmetic in nature)
- Craniofacial reconstruction (including but not limited to cleft lip repair)
- Craniotomy
- Dental anesthesia
- Certain Durable Medical Equipment (DME)
- Enteral solutions
- Endoscopy, Wireless Pill Video
- Epidural steroid injections
- Experimental/ investigational procedures and drugs
- Hearing aids
- Home health care
- Home sleep studies for Chronic Obstructive Sleep Apnea
- Hospice
- Hyperbaric Oxygen Treatment (HBO)
- Certain imaging studies (CT angiograms, CT scans, PET scans, MRA and MRI)
- Implantable defibrillators (AICD)
- Infertility services
- Intacs
- Interstim Therapy
- Intrathecal and epidural infusion pumps
- Laparoscopic Radical Prostatectomy
- Multidisciplinary rehabilitation services or programs
- Neuropsychological testing
- Orthognathic surgery
- Orthotripsy
- Oxygen therapy
- Pain management
- Penile Prosthesis Insertion
- PET scans
- Prosthetics and Orthotics
- Rehabilitation: ventilator
- Sclerotherapy or other varicose vein treatment
- Septoplasty

- Sexual dysfunction procedures
- Skilled nursing facility services
- Speech therapy (home or facility)
- Spinal cord stimulation
- Vagal Nerve Stimulation for Epilepsy
- Voluntary termination of pregnancy
- Any request for a referral to a non-Network Provider

List is subject to change. For the most current information, call Customer Service Department.

Decisions regarding requests for Authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

Section 16. Service Areas

Members must live must live or work in a Kaiser Service Area at the time of enrollment. You cannot continue enrollment as a Member if you move outside a Kaiser Permanente Service Area.

Service Areas by ZIP Code for Northern California

93230	93666	93764	94035	94119	94177	94277	94512
93232	93667	93765	94037	94120	94188	94278	94513
93242	93668	93771	94038	94121	94199	94279	94514
93601	93669	93772	94039	94122	94203	94280	94515
93602	93673	93773	94040	94123	94204	94282	94516
93604	93675	93774	94041	94124	94205	94283	94517
93606	93701	93775	94042	94125	94206	94284	94518
93607	93702	93776	94043	94126	94207	94285	94519
93609	93703	93777	94044	94127	94208	94286	94520
93611	93704	93778	94060	94128	94209	94287	94521
93612	93705	93779	94061	94129	94211	94288	94522
93613	93706	93780	94062	94130	94229	94289	94523
93614	93707	93784	94063	94131	94230	94290	94524
93616	93708	93786	94064	94132	94232	94291	94525
93618	93709	93790	94065	94133	94234	94293	94526
93619	93710	93791	94066	94134	94235	94294	94527
93623	93711	93792	94070	94135	94236	94295	94528
93624	93712	93793	94074	94136	94237	94296	94529
93625	93714	93794	94080	94137	94239	94297	94530
93626	93715	93844	94083	94138	94240	94298	94531
93627	93716	93888	94085	94139	94244	94301	94533
93630	93717	94002	94086	94140	94245	94302	94534
93631	93718	94005	94087	94141	94246	94303	94535
93636	93720	94010	94088	94142	94247	94304	94536
93637	93721	94011	94089	94143	94248	94305	94537
93638	93722	94013	94101	94144	94249	94306	94538
93639	93723	94014	94102	94145	94250	94309	94539
93643	93724	94015	94103	94146	94252	94401	94540
93644	93725	94016	94104	94147	94254	94402	94541
93645	93726	94017	94105	94150	94256	94403	94542
93646	93727	94018	94106	94151	94257	94404	94543
93648	93728	94019	94107	94152	94258	94497	94544
93649	93729	94020	94108	94155	94259	94501	94545
93650	93730	94021	94109	94156	94261	94502	94546
93651	93741	94022	94110	94158	94262	94503	94547
93652	93744	94023	94111	94159	94263	94505	94548
93653	93745	94024	94112	94160	94267	94506	94549
93654	93747	94025	94114	94161	94268	94507	94550
93656	93750	94026	94115	94162	94269	94508	94551
93657	93755	94027	94116	94163	94271	94509	94552
93660	93760	94028	94117	94164	94273	94510	94553
93662	93761	94030	94118	94172	94274	94511	94555

94556	94611	94924	95021	95135	95240	95404	95625
94557	94612	94925	95026	95136	95241	95405	95626
94558	94613	94927	95030	95138	95242	95406	95628
94559	94614	94928	95031	95139	95253	95407	95630
94560	94615	94929	95032	95140	95258	95409	95632
94561	94617	94930	95033	95141	95267	95416	95633
94562	94618	94931	95035	95148	95269	95419	95634
94563	94619	94933	95036	95150	95296	95421	95635
94564	94620	94937	95037	95151	95297	95425	95638
94565	94621	94938	95038	95152	95304	95430	95639
94566	94622	94939	95042	95153	95307	95431	95640
94567	94623	94940	95044	95154	95313	95433	95641
94568	94624	94941	95046	95155	95316	95436	95645
94569	94649	94942	95050	95156	95319	95439	95648
94570	94659	94945	95051	95157	95320	95441	95650
94571	94660	94946	95052	95158	95323	95442	95651
94572	94661	94947	95053	95159	95326	95444	95652
94573	94662	94948	95054	95160	95328	95446	95655
94574	94666	94949	95055	95161	95329	95448	95658
94575	94701	94950	95056	95164	95330	95450	95659
94576	94702	94951	95070	95170	95336	95452	95660
94577	94703	94952	95071	95172	95337	95462	95661
94578	94704	94953	95101	95173	95350	95465	95662
94579	94705	94954	95103	95190	95351	95471	95663
94580	94706	94955	95106	95191	95352	95472	95664
94581	94707	94956	95108	95192	95353	95473	95667
94582	94708	94957	95109	95193	95354	95476	95668
94583	94709	94960	95110	95194	95355	95486	95669
94585	94710	94963	95111	95196	95356	95487	95670
94586	94712	94964	95112	95201	95357	95492	95671
94587	94720	94965	95113	95202	95358	95602	95672
94588	94801	94966	95115	95203	95360	95603	95673
94589	94802	94970	95116	95204	95361	95604	95674
94590	94803	94971	95117	95205	95363	95605	95676
94591	94804	94972	95118	95206	95366	95607	95677
94592	94805	94973	95119	95207	95367	95608	95678
94595	94806	94974	95120	95208	95368	95609	95680
94596	94807	94975	95121	95209	95376	95610	95681
94597	94808	94976	95122	95210	95377	95611	95682
94598	94820	94977	95123	95211	95378	95612	95683
94599	94850	94978	95124	95212	95380	95613	95686
94601	94901	94979	95125	95213	95381	95614	95687
94602	94903	94999	95126	95215	95382	95615	95688
94603	94904	95002	95127	95219	95385	95616	95690
94604	94912	95008	95128	95220	95386	95617	95691
94605	94913	95009	95129	95227	95387	95618	95692
94606	94914	95011	95130	95230	95391	95619	95693
94607	94915	95013	95131	95231	95397	95620	95694
94608	94920	95014	95132	95234	95401	95621	95695
94609	94922	95015	95133	95236	95402	95623	95696
94610	94923	95020	95134	95237	95403	95624	95697

95698	95757	95799	95818	95826	95834	95843	95867
95703	95758	95811	95819	95827	95835	95851	95894
95722	95759	95812	95820	95828	95836	95852	95899
95736	95762	95813	95821	95829	95837	95853	95903
95741	95763	95814	95822	95830	95838	95860	95961
95742	95765	95815	95823	95831	95840	95864	
95746	95776	95816	95824	95832	95841	95865	
95747	95798	95817	95825	95833	95842	95866	

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Section 17. Customer Service Phone Numbers

General Member Service
Northern California Region
800-663-1771

Utilization Management for Out-of Network Emergency Services
Northern California Region
800-225-8883

Advice Nurses
Northern California Region
800-663-1771

Interpreter Services
Northern California Region
800-663-1771

Pharmacy Benefit Information
All Regions
866-427-7701

Claims Administrator
KPIC Self-Funded Claims Administrator
P.O. Box 30547
Salt Lake City, UT 84130-0547
Payor ID # 94320

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