SAND2014-3912P

Sandia National Laboratories

Sandia Flexible Spending Accounts Plan

Revised January 1, 2014

Summary Plan Description

Important

This Summary Plan Description (including documents incorporated by reference) applies to both non-represented employees and represented employees, effective January 1, 2014.

The Sandia Flexible Spending Accounts Plan is maintained at the discretion of Sandia and is not intended to create a contract of employment and does not change the at-will employment relationship between you and Sandia. The Sandia Flexible Spending Accounts Plan is expected to continue indefinitely. However, the Sandia Board of Directors (or designated representative) reserves the right to amend (in writing) any or all provisions of the Sandia Flexible Spending Accounts Plan and to terminate (in writing) the Sandia Flexible Spending Accounts Plan at any time without prior notice, subject to applicable collective bargaining agreements. If the Plan is terminated, coverage under the Plan for you and your dependents will end, and payments under the Plan will generally be limited to covered expenses incurred before the termination.

The Sandia Flexible Spending Accounts Plan cannot be modified by written or oral statements to you from human resources representatives or from HBE personnel or any other Sandia personnel.

U.S. DEPARTMENT OF ENERGY

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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Section 1. Introduction

This Summary Plan Description (SPD) is intended to provide a summary of the principal features of Sandia Flexible Spending Accounts Plan. This SPD highlights the key features and provisions of the Health Care Flexible Spending Account (Health Care FSA) and the Dependent Care Flexible Spending Account (Day Care FSA) at Sandia and throughout this SPD. Please read this SPD carefully so that you fully understand the FSA benefits offered by the Plan.

This SPD is a summary of your FSA benefits. It does not include the complete details of the Sandia Flexible Spending Accounts Plan. Every effort has been made to ensure that the information in this SPD is complete and accurate. However, if there is ever a conflict or a difference between what is written here and the official Plan document, the terms of the official Plan document will govern.

Flexible Spending Accounts (FSAs) are authorized under and subject to federal tax laws, such as the Internal Revenue Code and other federal and state laws which may affect your rights. The provisions of the Plan(s) are subject to revision due to a change in laws or pronouncements by the Internal Revenue Service (IRS) or other federal agencies.

In general, this SPD will cover eligibility; events allowing enrollment and disenrollment; FSA contributions; general information; how the FSAs work, claims and appeals information; and when coverage ends for the Health Care FSA and Day Care FSA offered by Sandia to its employees. In addition, this SPD will cover continuation of group health coverage and your rights under ERISA for the Health Care FSA. The Day Care FSA is not subject to ERISA.

Certain capitalized words in this SPD have special meaning. These words have been defined in Section 13, Definitions.

To receive a paper copy of this SPD (including other documents incorporated by reference), please contact Sandia HBE Customer Service at 505-844-HBES (4237) or hbe.sandia.gov.

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

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Section 2. Summary of Changes

This section highlights the changes made to the FSAs effective January 1, 2014:

- The Flexible Spending Account (FSA) Administrator for Blue Cross Blue Shield participants is now Connect Your Care.

- The Flexible Spending Account (FSA) Administrator for Kaiser Permanente participants is now Kaiser Permanente Health Payment Services.

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Section 3. Eligibility Information

This section outlines employee eligibility for the Health Care FSA and the Day Care FSA and dependent definitions for the purpose of eligible expenses.

The following table outlines the eligibility for employees for the Health Care FSA and Day Care FSA:

Classification	Health Care FSA	Day Care FSA
Regular full- or part-time employee	Yes	Yes
Limited-term full-or part-time exempt employee	Yes	Yes
Limited-term full- or part-time non-exempt employee	Yes	Yes
Full- or part-time Post-Doctoral Appointee	Yes	Yes
Year-round student intern employee (with the exception of student intern fellowship programs)	No	No
Summer student intern employee	No	No
Recurrent employee	No	No
Faculty Sabbatical Appointee employee	No	No

For purposes of coverage under the Health Care FSA and the Day Care FSA, an employee is eligible only if:

- He/she has satisfied all requirements for coverage under the Sandia Flexible Spending Accounts Plan
- Sandia withholds required federal, state, or FICA taxes from his/her paycheck

EXCEPTION: An employee receiving benefits under Sandia's Job Incurred Accident Disability Plan who does not have taxes withheld by Sandia from his/her paycheck, but who otherwise satisfies the eligibility requirements of the Sandia Flexible Spending Accounts Plan, is an "employee" for purposes of coverage under the Sandia Flexible Spending Accounts Plan.

For Rehired Employees

If you separate from Sandia (a leave of absence is not considered a separation) and are rehired within 30 days in the same calendar year, and you previously had either a Health Care FSA or Day Care FSA, your annual election amount must be reinstated. Please contact the Benefits Department to ensure your account is reinstated. If rehired after 30 days in the same calendar year, you can keep your previous annual election/contribution amount, elect a new annual election/contribution amount, or elect not to contribute.

Sandia Spouse as Eligible Employee

An eligible Sandia employee and his or her Spouse who is also an eligible Sandia employee may each have separate Health Care FSAs. Each Sandia employee may open a Health Care FSA for the maximum annual election amount of $2,500. An employee does not have to be the primary participant under the health care plans in order to open up a Health Care FSA and obtain reimbursement for qualified dependents.

Example: Two Sandia employees are married to each other. The wife enrolls in a Sandia medical Program and lists her husband as a dependent. The husband opens a Heath Care FSA for $2500. The wife has LASIK eye surgery in January that cost $1,500. Her husband can file a claim for the LASIK eye surgery against his Health Care FSA.

Example: Two Sandia employees are married to each other and file joint federal tax returns. One has elected to cover his Spouse and their children as dependents under a Sandia medical Program. The other Spouse has elected to enroll in a Health Care FSA to be reimbursed for eligible expenses for her Spouse, herself, and their children, whom they claim as dependents on their federal income tax return. This is allowed.

An eligible Sandia employee and his or her Spouse who is also an eligible Sandia employee may each have separate Day Care FSAs. However, the Day Care FSA is limited to a combined maximum annual election amount of $5,000, subject to the rules stated in Section 8 Contributions.

Eligible Dependents

This section outlines the dependents for whom expenses are eligible for reimbursement.

The Health Care FSA allows you to use before-tax dollars to help pay for out-of-pocket eligible health care expenses for you and your eligible family members. Your eligible family members include:

- Your opposite sex spouse, or domestic partner who is a federal tax dependent,
- Your children will be eligible dependents until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Plan participant or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the calendar year.
- Your mentally or physically disabled adult dependent children who live with you and who are primarily dependent on you for support,
- The dependent children of your domestic partner, as long as you claim them as dependents on your tax return, and
- Any other person who meets the Internal Revenue Service (IRS) definition of a tax dependent (without regard to the income limit) which means an individual whose primary residence is your home, who is a member of your household, for whom you provide more than one-half of their support, and who is not the *qualifying child* of the employee or any other individual. (Note, an employee can treat another person's qualifying child as a qualifying relative if the child satisfies the other requirements listed here and if the other person isn't required to file a tax return and either doesn't file a return or files one only to get a refund of withheld income taxes. For example, this could allow tax-free health coverage for the children of an employee's non-working domestic partner.)

- **Note on children of divorced parents**: Children of divorced or separated parents can be covered as a dependent of both parents for purposes of tax-free health coverage **if** the child: (1) receives over half his or her annual support from his or her parents, (2) is in the custody of one or both the parents for more than half the year, and (3) otherwise qualifies under one of the last four descriptions, above, with respect to one of the parents.

Tax Consequences of Domestic Partner Benefits

Unless your domestic partner or your domestic partner's dependent children, if any, are considered your dependents for health care purposes, under the Internal Revenue Code, the Internal Revenue Service currently treats as imputed income to you the value of the coverage provided for your domestic partner and your domestic partner's dependent children, if any, less any contributions paid by you on an after-tax basis for this coverage. In general, a domestic partner (or child of a domestic partner) who is a member of your household qualifies as your tax dependent for health benefit purposes if:

- He or she receives more than 50% of his or her financial support from you;
- He or she lives with you (shares a personal residence) for the full tax year (except for temporary reasons such as vacation, military service or education);
- He or she is a citizen, national or legal resident of the United State; or a resident of Canada or Mexico; or is a child being adopted by a US citizen or national;
- He or she is not a section 152 qualifying child dependent on another taxpayer's filed return or is a section 152 qualifying child dependent on another taxpayer's return where the filing is only to obtain a refund of withheld income taxes; and
- Your relationship is not in violation of any local laws.

You are advised to consult with your tax advisor to determine if your domestic partner and your domestic partner's dependent children are your federal tax dependents and to review the tax consequences for electing domestic partner benefit coverage.

In general, state income tax treatment of domestic partner benefits is the same as the federal income tax treatment. However, certain benefits for domestic partners and their children who are not your tax-free health care dependents under the Code may be eligible for special state income tax treatment in a few select states. Please speak to your tax advisor regarding whether your domestic partner and his or her children, if any, qualify for the special state income tax treatment. If they do qualify, you must notify Sandia immediately in writing of this special state income tax status.

IMPORTANT: It is your responsibility to determine if your dependents expenses are eligible for reimbursement. See Internal Revenue Service (IRS) Publication 502 for help in determining who is a qualifying child or a qualifying relative for purposes of reimbursement under the Health Care FSA. Should the Internal Revenue Service audit your tax return and determine you have obtained tax benefits for which you are not eligible, you are responsible for any overdue taxes, interest, and penalties.

For purposes of the Day Care FSA, your eligible dependents include the following:

- Your child under age 13 and who is your *qualifying child*;
- Your Spouse, if physically or mentally incapable of self-care and lives with you for more than half the year; and
- Any other individual over age 13 who is physically or mentally incapable of caring for him or herself, who lives with you, receives over half of his or her support from you, and who is not the *qualifying child* of you or any other individual.

Qualified Medical Child Support Order (QMCSO)

Generally, your Sandia health benefits may not be assigned or alienated. However, an exception applies in the case of any child of a participant (as defined by ERISA) who is recognized as an alternate recipient in a Qualified Medical Child Support Order (QMCSO). A QMCSO is any judgment, decree, or order (including a court-approved settlement agreement) that is issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law, which has the force and effect of law in that state; that assigns to a child the right of a participant or beneficiary to receive benefits under an employer-provided health plan, regardless of with whom the child resides; and that Sandia has determined is qualified under the terms of ERISA and applicable state law. The Sandia Health Care FSA will comply with the terms of a QMCSO. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a QMCSO. Sandia's Legal Organization will review the medical child support order to determine whether it meets the criteria for a QMSCO. If you have questions about or wish to obtain a copy of the procedures governing a QMCSO Determination (at no charge), contact Sandia Benefits HBE at 505-844-HBES (4237).

Section 4. Enrollment/Disenrollment Events

This section outlines those events that allow enrollment into or disenrollment from the Health Care FSA and Day Care FSA.

When You Can Enroll

You can enroll yourself in the Health Care FSA and Day Care FSA:

- Upon becoming a new employee
- During the annual open enrollment
- Upon a mid-year election change event

When You Can Disenroll

You can disenroll yourself from the Sandia Health Care FSA and Day Care FSA:

- Upon a mid-year election change event

Enrolling as a New Employee or Reclassified Employee

As a new employee, you can enroll yourself in the Health Care FSA and Day Care FSA on the Sandia internal web through HR Self-Service/Benefits/Benefits Enrollment.

IMPORTANT: You must submit your election within 30-calendar days of hire. Coverage will be retroactive to your date of hire. If you miss the 30 calendar day enrollment window, you will have to wait until the next Open Enrollment period to enroll (unless you have a mid-year election change event) and your coverage will be considered as waived.

If you terminate employment with Sandia and are rehired within 30 days after terminating employment (or if you return to employment after being terminated for less than 30 days), you will automatically be reinstated to your Health Care FSA and Day Care FSA elections you had prior to termination. Please contact the Benefits Department to ensure your account is reinstated.

Enrolling During Annual Open Enrollment

Every year in the fall you have the option to enroll in the Health Care FSA and Day Care FSA. Open Enrollment is done through the web-based open enrollment system. Elections made during Open Enrollment take effect January 1 of the following calendar year. If you do not enroll in Health Care FSA or Day Care FSA, you will not be able to participate during the following year unless you have a mid-year election change event.

Mid-Year Election Change Events

The information in this section lists the mid-year election change events permitting enrollments, changes, and/or disenrollments. Not every mid-year election change event, however, permits enrollment, a change in election amount, or a disenrollment. Also, see Section 11, Continuation of Group Health Coverage for information on allowable changes during a leave of absence, sickness absence, or an unpaid absence.

You have 31 calendar days from the date of the mid-year election change event to make a mid-year change, to enroll, or to disenroll. The effective date of the change is the later of the date of the mid-year election change event or the date the Benefits Department receives completed paperwork.

Mid-year change events will typically result in the FSA administration remaining with the original FSA administrator who began administering your FSA plan at the beginning of the plan year. During Open Enrollment, the plan administrator may change, based on your health care election. For further clarification about administrator changes and/or impact mid-year, please contact HBE Customer Service at 505-844-HBES (4237) for additional information.

Changes/enrollments/disenrollments are subject to review by the Sandia FSA Health Plan Specialist. Contact the HBE Customer Service at 505-844-HBES (4237) for additional information.

Health Care FSA Mid-Year Election Qualified Changes

Health Care Flexible Spending Account changes require a gain or loss of health care coverage. There must be both:

- a gain or loss of eligibility for health care coverage, and
- a corresponding gain or loss in health care coverage, and
- the request must be consistent with and on account of the change in status.

An unanticipated medical expense is not an eligible mid-year election change event.

Qualified changes in status

Event	Health Care FSA	Day Care FSA
Change in legal marital status		
Marriage	Increase election *or* Decrease election if family members become covered under spouse's health plan [1]	Increase election if marriage increases dependent care expenses [2] *or* Decrease election if family elects dependent care assistance under spouse's plan or marriage lowers dependent care expenses [2]
Divorce, legal separation, or annulment	Increase election if event causes loss of coverage under spouse's health plan [1] *or* Decrease election	Increase election if event increases dependent care expenses [2] or causes loss of coverage under spouse's plan *or* Decrease election if event lowers dependent care expenses [2]

Event	Health Care FSA	Day Care FSA
Spouse's death	Increase election if death causes loss of coverage under spouse's health plan [1] *or* Decrease election	Increase election if death causes loss of coverage under spouse's plan or increases dependent care expenses [2] *or* Decrease election if death lowers dependent care expenses [2]
Change in number of dependents		
Employee gains tax dependent (e.g., by birth, adoption, or placement for adoption)	Increase election	Increase election if employee has greater dependent care expenses
Employee loses tax dependent (e.g., child dies or becomes self-supporting)	Decrease election	Decrease election if employee has lower dependent care expenses
Change in dependent eligibility		
Dependent loses eligibility under plan on account of age, student status, or any similar circumstance	Decrease election	Decrease election if event reduces dependent care expenses [2]
Dependent becomes eligible under plan on account of age, student status, or any similar circumstance (e.g. plan amended to permit dependent coverage)	Increase election	Increase election if event increases dependent care expenses [2]
Change in employee's employment status		
Employee terminates employment, triggering loss of coverage under employer's plan	Stop contributions *or* Increase election (from available earnings) to pay for FSA COBRA coverage	Stop contributions
Employee is rehired more than 30 days after termination of employment	Reinstate prior election *or* Make election to same extent as permitted new hires	Reinstate prior election *or* Make election to same extent as permitted new hires
Employee is rehired within 30 days after termination of employment	Reinstate prior election unless intervening status change event	Reinstate prior election unless intervening status change event
Employee is out of work due to strike or lockout that affects eligibility for coverage	Stop contributions *or* Increase election (from available earnings) to pay for FSA COBRA coverage	Stop contributions
Employee returns to work after end of strike or lockout that affected eligibility for coverage	Reinstate prior election *or* Make election to same extent as permitted new hires *or* Decrease election if previously paying for FSA COBRA coverage	Reinstate prior election *or* Make election to same extent as permitted new hires
Employee begins unpaid leave	Stop contributions if event causes loss of coverage *or* Increase election before leave to prepay FSA COBRA coverage	Decrease election if event causes loss of coverage or lowers dependent care expenses [2]

Event	Health Care FSA	Day Care FSA
Employee returns more than 30 days after start of unpaid leave	Reinstate prior election *or* Make election to same extent permitted as new hires if event causes employee to become eligible	Reinstate prior election *or* Make election to same extent permitted as new hires if event causes employee to become eligible *or* Increase election if event increases dependent care expenses [2]
Employee returns within 30 days after start of unpaid leave	Reinstate prior election unless intervening status change event	Reinstate prior election unless intervening status change event *or* Increase election if event increases dependent care expenses [2]
Employee begins FMLA leave	Stop contributions *or* Increase election to prepay coverage during leave	Decrease election if leave causes loss of coverage or lowers dependent care expenses [2] *or* Increase election to prepay if coverage permitted during leave
Employee returns from FMLA leave	Generally same rights as employees returning from other leave, though employee must be able to reinstate prior coverage If health care FSA lapsed during leave, employee can resume coverage at prior level (and pay missed contributions) or at reduced pro rata level	Generally same rights as employees returning from other leave, though employee must be able to reinstate prior coverage
Employee begins Furlough	Stop contributions *or* Increase election to prepay coverage during leave	Decrease election if event causes loss of coverage or lowers dependent care expenses [2]
Employee returns from Furlough	Reinstate prior election unless intervening status change event	Reinstate prior election unless intervening status change event *or* Increase election if event increases dependent care expenses [2]
Employee begins paid leave without any change in eligibility	No change	Decrease election if event lowers dependent care expenses [2]
Employee returns from paid leave	No change	Increase election if event increases dependent care expenses [2]
Other changes in employment status (e.g., switch from salaried to hourly status) causes employee to lose eligibility under plan	Cease contributions	Cease contributions *or* Decrease election if event decreases dependent care expenses [2]

Event	Health Care FSA	Day Care FSA
Other change in employment status (e.g., switch from hourly to salaried status) causes employee to become eligible under plan	Elect to contribute to newly available coverage	Elect to contribute to newly available coverage *or* Increase election if event increases dependent care expenses [2]
Other change in employment status (e.g., between full-time and part-time status) significantly changes cost or coverage	See change in cost or change in coverage rules	See change in cost or change in coverage rules
Change in spouse or dependent employment status		
Spouse or dependent terminates employment	Increase election if event adversely affects eligibility for coverage under spouse's or dependent's health plan [1]	Increase election if event adversely affects eligibility for coverage under spouse's dependent care assistance plan *or* Decrease election if event decreases dependent care expenses [2]
Spouse or dependent begins employment	Decrease election if family becomes covered under spouse's or dependent's health plan [1]	Increase election if event increases dependent care expenses [2] *or* Decrease election if family becomes covered under spouse's dependent care assistance plan
Spouse or dependent is out of work due to strike or lockout	Increase election if event adversely affects eligibility under spouse's or dependent's health plan [1]	Increase election if event adversely affects eligibility under spouse's dependent care assistance plan *or* Decrease election if event lowers dependent care expenses [2]
Spouse or dependent returns to work after strike or lockout ends	Decrease election if family becomes covered under spouse's or dependent's health plan [1]	Increase election if event increases dependent care expenses [2] *or* Decrease election if family becomes covered under spouse's dependent care assistance plan
Spouse or dependent begins unpaid leave	Increase election if event adversely affects eligibility under spouse's or dependent's health plan [1]	Increase election if event adversely affects eligibility under spouse's dependent care assistance plan *or* Decrease election if event lowers dependent care expenses [2]

Event	Health Care FSA	Day Care FSA
Spouse or dependent returns from unpaid leave	Decrease election if family becomes covered under spouse's or dependent's health plan [1]	Increase election if event increases dependent care expenses [2] *or* Decrease election if family becomes covered under spouse's dependent care assistance plan
Spouse or dependent changes worksite	Increase election if event adversely affects eligibility under spouse's or dependent's health plan [1] Decrease election if event makes new coverage available under spouse's or dependent's health plan	Increase election if event adversely affects eligibility under spouse's plan *or* Decrease election if family becomes covered under spouse's plan *or* Increase/decrease election if event increases/lowers dependent care expenses [2]
Other change in employment status (e.g., switch from salaried to hourly status) causes spouse or dependent to lose eligibility under spouse's or dependent's plan	Increase election [1]	Increase election if event adversely affects eligibility under spouse's plan *or* Decrease election if event lowers dependent care expenses [2]
Other change in employment status (e.g., switch from hourly to salaried status) causes spouse or dependent to gain eligibility under spouse's or dependent's plan	Decrease election if family members become covered under spouse's or dependent's health plan [1]	Decrease election *or* Increase election if event increases dependent care expenses [2]
Other events		
Loss of other coverage entities employee or family member to enroll under HIPAA	Increase election	None
Judgment, decree, or order (including QMCSCO) relating to accident/health coverage for child	Increase election if ordered to provide child's health coverage, or decrease election if other parent covers child under order	None
Employee, spouse, or dependent enrolled in employer's accident/health plan becomes entitled to Medicare or Medicaid	Decrease election	None
Employee, spouse, or dependent loses entitlement to Medicare, Medicaid, SCHIP, or any group health coverage sponsored by governmental or educational institution	Increase election	None
Change in coverage – employer's plan		

Event	Health Care FSA	Day Care FSA
Employer adds family coverage or other new coverage option	None	Switch from current option to new option *or* Elect new option if coverage previously declined
Employer eliminates family coverage or other coverage option	None	Switch into another option *or* Drop coverage if similar coverage is unavailable
Employer adds new qualified benefit	None	Elect new benefit
Employer eliminates qualified benefit	None	Drop benefit
Coverage is significantly curtailed or ceases	None	Switch to different option *or* Drop coverage if coverage ceases or is so severely curtailed that it amounts to loss of coverage and similar coverage is unavailable
Existing benefit option is significantly improved	None	Switch to improved option *or* Elect improved option if coverage previously declined
Employee changes child care provider or number of hours worked by child care provider	None	Make election change that corresponds to new costs
Change in cost – employer's plan		
Cost of benefit option changes and plan provides for automatic change in election	None	Employer increases or decreases payments per plan terms (relevant for on-site day care)
Cost of option significantly decreases and plan doesn't provide for automatic change in election	None	If day care provider lowers rates midyear (and provider is not employee's relative): Decrease election
Cost of benefit option significantly increases and plan doesn't provide for automatic change in election	None	If day care provider raises rates midyear (and provider is not employee's relative): Increase election *or* Switch to different provider and adjust election as needed
Election change under spouse's or dependent's employer plan		
Individual changes election during open enrollment period that differs from the open enrollment period under employer's plan	None	Employee can make election change that "corresponds" with election change
Individual changes election for any other event permitted under regulation (and terms of employer plan)	None	Employee can make election change that "corresponds" with election change

Event	Health Care FSA	Day Care FSA
[1] This does not require that a spouse's coverage include an FSA. [2] The chart's reference to an increase or decrease in dependent care expenses means that the event changes the amount of expenses that an employee can have reimbursed on a tax-free basis from a dependent care assistance plan under Code section 129.		

How to Complete A Mid-Year Change (Enroll or Change Account)

- Complete the Flexible Spending Account Mid-Year Election Change Request Form found in the Employee Health Plan Benefits Enrollment/Disenrollment Packet (SF 4400-PKG)
- Retain a copy for your files

Fax the original within 31 days of the event to meet the required enrollment time frame, to the Sandia Benefits HBE, 505-844-7535.

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

Section 5. Contributions

Before the start of each Plan Year (during the annual Open Enrollment held each fall), you must designate the amount of money you wish to have withheld from your pay to be contributed to your Health Care FSA and/or your Day Care FSA. This is called your "plan year election." The money you have set aside will be available for payment of your qualifying health care and/or dependent care expenses based on your election. See Sections 7 and 8 for a description of qualifying expenses. The amount withheld is contributed to your accounts through the 26 annual payroll deductions. Your contributions are processed on a pre-tax basis and not subject to Federal income or Social Security/Medicare taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of expenses which you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Health Care FSA or Day Care FSA, you cannot claim a Federal income tax credit or deduction on your income tax return for that expense.

Contributions Minimum and Maximum: Health Care FSA

- Minimum election amount of $100 per Plan Year
- Maximum election amount is $2,500 per Plan Year

Contributions Minimum and Maximum: Day Care FSA

The amount of Day Care FSA contributions that you elect cannot exceed the maximum amount specified in Code Section 129.

- Minimum election amount of $100 per Plan Year
- Maximum election amount is $5,000 per Plan Year

If you:

- Are married and file a joint return
- Are single

See Section 8, How the Day Care FSA Works, for other contribution limits that apply to the Day Care FSA.

Contributions during a Leave of Absence

Sandia provides various leaves of absence programs for eligible employees. Refer to the applicable Corporate Policy on Leaves of Absence for eligibility information as well as other general information on leaves of absence. Refer to Section 11, Continuation of Group Health Coverage for information on continuing your coverage while on a leave of absence.

If you continue your Health Care FSA coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

COBRA Premium

Sandia requires persons who elect continuation of the employer-provided health coverage to pay the full cost of the coverage, plus a two percent administrative charge. COBRA continuation coverage lasts only for a limited period of time. See Section 11, Continuation of Group Health Coverage for more information. COBRA may be available for the Health Care FSA.

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Section 6. General Information

This section provides information on the tax and benefit effects of participating in the FSAs.

Tax Advantages of Participating

Flexible Spending Accounts offer significant tax savings because they allow you to set aside money from your paycheck before federal, Social Security/Medicare and, in most cases, state and local taxes are calculated. As a result, you lower your taxable income, pay lower taxes and increase your take-home pay. In addition, the money in your accounts is never taxed, even when you receive a reimbursement. Should you have questions about tax advantages of participating in a Flexible Spending Account, please consult your tax advisor.

Effect on Other Benefits

Generally, participating in either spending account will have no effect on your other Sandia benefit coverage. However, because you pay no Social Security taxes on the amounts set aside in the accounts, participation may reduce future Social Security benefits. You may want to discuss this with a tax adviser before deciding to contribute to a spending account.

Eligible expenses under the Day Care FSA are the same expenses that would permit a dependent care tax credit on your federal income tax return. It is up to you to decide which one would be more advantageous based on your personal situation. To help determine whether the federal child and dependent care tax credit or the Day Care FSA would be more advantageous to you, you may wish to consult a qualified tax advisor.

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Section 7. How the Health Care FSA Works

You can use the money in your Health Care FSA to pay for eligible health care expenses that you and your dependents incur, provided those expenses are not covered by any other source.

Here's how the account works:

- You decide how much to contribute to your Health Care FSA based on expenses you expect to incur during the year;
- Contributions are deducted from your pay on a pre-tax basis each pay period;
- When you or a dependent has eligible health care expenses not covered by any other source such as a medical or dental plan, you submit a claim for reimbursement and,
- You will be reimbursed for the amount of your claim, up to the total annual amount you elected to contribute to the Health Care FSA, reduced by any reimbursements already made to you.

Contributions

When you enroll, you decide how much you want to contribute to the Health Care FSA. You can contribute up to $2,500 each year. Contributions are deducted evenly from each paycheck throughout the year on a pre-tax basis.

Eligible Dependents

You may submit health care expenses incurred by you, your spouse, and your eligible dependents as listed in the Eligible Dependents section.

Eligible Expenses

The Health Care FSA is an account that allows you to put money aside to reimburse yourself for "eligible" health care expenses. Expenses must be incurred during the Plan Year and while you were covered under the Plan. An expense is considered incurred when the care or service is provided—not when your provider issues a bill, nor when you receive or pay that bill. The Plan will offer a "grace period" where you can continue to incur claims after the end of the Plan Year for reimbursement from unused Health Care FSA funds. This grace period allows you to incur expenses until March 15th following the Plan Year. You may submit bills for any expense for medical care, as defined in Internal Revenue Code Section 213 (except long-term care premiums and expenses associated with long-term care and other health care premiums), which you are obligated to pay and which are not covered by any plan.

This may include amounts that are not paid by your or your spouse's employer-sponsored health care plan, such as deductibles, co-payments, expenses in excess of plan dollar limits, or those which exceed customary and reasonable fees. You may also submit bills for medical, dental, and vision expenses that are not reimbursed by another plan so long as they are medical expenses you could have claimed on your individual income tax return as a qualified medical expense per the Internal Revenue Code.

Expenses eligible to be reimbursed from the Health Care FSA include expenses for the diagnosis, cure, treatment or prevention of disease, and for treatments affecting any part or function of the body. Expenses must be to alleviate or prevent a physical or mental defect or illness. Expenses incurred solely for cosmetic reasons or expenses that are merely beneficial to a person's general health (except smoking cessation and physician-directed weight reduction programs) are not eligible for reimbursement.

Below is a partial list of expenses eligible for reimbursement under the Health Care FSA:

Medical Expenses

- Deductibles
- Copayments
- Coinsurance
- Charges for routine check-ups, physical examinations, and tests connected with routine exams
- Charges over the "reasonable and customary" limits
- Expenses not covered by the medical plan due to a pre-existing condition, or exclusion by the insurance company
- Drugs requiring a doctor's written prescription that are not covered by insurance
- Insulin
- Smoking cessation programs and related medicines
- Weight loss programs which are at the direction of a physician to treat a medical condition such as hypertension (weight loss programs for general health improvement do not qualify)
- Other selected expenses not covered by the medical plan that qualify for a federal income tax deduction, such as special services and supplies for the disabled (such as seeing eye dogs for the blind, dentures and artificial limbs, wheelchairs and crutches).

Dental Expenses

- Deductibles
- Copayments
- Coinsurance
- Expenses that exceed the maximum annual amount allowed by your dental plan
- Charges over the "reasonable and customary" limits
- Orthodontia treatments that are not strictly cosmetic

Vision and Hearing Expenses

- Vision examinations and treatment not covered by insurance plan
- Cost of eyeglasses, laser surgery, prescription sunglasses, contact lenses including lens solution and enzyme cleaner
- Cost of hearing exams, aids and batteries

Transportation

Amounts paid for transportation for health care can be claimed. Transportation costs do not include the cost of any meals and lodging while away from home and receiving health care treatment.

Extension for Incurring Expenses (Grace Period)

If you have unused contributions in your account at the end of the current Plan year you can continue to incur expenses through March 15 immediately following the end of the Plan year and receive reimbursement for these expenses until such unused funds are depleted. All requests for reimbursement will be accepted and processed through April 15. After April 15 funds remaining in your account for the current Plan year will be forfeited. Unused benefits relating to a particular qualified benefit (e.g. Health Care FSA) may only be used to pay expenses incurred with respect to that particular benefit and cannot be transferred to another account.

If you elect a Health Care FSA plan year after year, and you switch medical plan administrators from one calendar year to the next calendar year, see Appendices C through G for guidance on how to submit claims and apply for reimbursement between the three administrators.

Ineligible Expenses

Below is a partial list of expenses not eligible for reimbursement under the Health Care FSA:

- Premiums
    1. Premiums paid by the Employee, a Spouse or other dependents for coverage under any health plan
    2. Premiums paid for Medicare
    3. Premiums paid for long term-care insurance
    4. Premiums paid for policies that provide coverage for loss of earnings, accidental death, loss of limbs, loss of sight, etc.
- Non-prescription drugs not used to treat a specific medical condition (e.g., merely beneficial to general health), vitamins and dietary supplements
- Over-the-counter drugs (OTC) are typically considered ineligible expenses. Please note: (OTC) drug and medicine purchases will require individuals to obtain a prescription from a doctor if you would like to submit the expense towards the Health Care FSA. This new rule does not apply to reimbursements for insulin which will continue to be permitted without a prescription. The OTC provision is part of the Healthcare Reform legislation passed by Congress. FSA administrators and Sandia are required by the federal government to follow this new rule.
- Cosmetic Procedures that are strictly cosmetic, such as electrolysis, teeth bleaching, hair transplants or plastic surgery is not an expense for medical care.
- Expenses Related to General Health — Expenses incurred must be primarily for the prevention or alleviation of a physical or mental illness or defect. Therefore, an expense which is merely beneficial to the general health of an individual (such as expenditures for vacation or health club dues, even if prescribed by a doctor) is generally not an expense for medical care. Generally only foods prescribed by your doctor as supplements to the normal diet may qualify as a medical expense.
- Long Term Care Expenses
- Virgin Pulse Pedometers - Pedometers are not an eligible expense item, unless there is a Letter of Medical Necessity, indicating a pedometer is needed to combat a specific disease or illness. Pedometers are considered to be used for general good health, so they are not eligible for reimbursement through a FSA.

The IRS does not allow you to deduct the same expenses on your income tax return for which you are reimbursed under the Health Care FSA.

These are general examples of reimbursable expenses and excludible expenses. Actual claims must satisfy the Internal Revenue Code rules for tax deductibility. For more information, contact the Claims Administrator.

Claims Filing

For reimbursement from your Health Care FSA, you must include proof of the expenses incurred. Proof can include a bill, invoice, or an Explanation of Benefits (EOB) from any group medical/dental plan under which you are covered. An EOB will be required if the expenses are for services usually covered under group medical and dental plans, for example, charges by surgeons, doctors and hospitals. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other group medical/dental plans are made.

Only expenses which are incurred while you are a participant in the Plan or during the grace period (March 15) immediately following the end of the Plan year may be reimbursed from a Health Care FSA. In addition, expenses which are incurred during one Plan year, with the exception of expenses incurred during the grace period immediately following the end of the Plan year, cannot be reimbursed from funds contributed to your Health Care FSA during another Plan year. An expense is considered incurred when services are provided, not when you are billed or when you pay for care.

If you have established a Health Care FSA, your total annual contribution amount is available immediately. You can request reimbursement for eligible expenses up to your annual contribution amount as soon as such eligible expenses have been incurred.

Requests for withdrawal will be accepted and processed through April 15 of the following year for expenses incurred during the Plan year and grace period immediately following the end of the Plan year.

In accordance with IRS regulations, amounts contributed to your Health Care FSA during the Plan year but remaining in your account at the end of the processing period (April 15 of the following year) cannot be returned to you or used to reimburse expenses incurred in a subsequent Plan year. These amounts are forfeited.

Claims Filing without Debit Cards

You must follow the claims filing procedures established by the Health Care FSA Plan Claims Administrator. See the Claims Filing Process section in Appendix D and the Claims Filing Process section of Appendix G.

Claims Filing and Debit Cards

You must follow the claims procedures established by the Health Care FSA Plan Claims Administrator. See the Claims Filing Process section in Appendix C, the Claims Filing Process section in Appendix E, and the Claims Filing Process section in Appendix F.

You may also obtain a claim form from Sandia Corporate Forms or from Sandia Benefits at 505-844-HBES (4237).

Use or Lose

IRS regulations stipulate that you must use the full amount of money in your Health Care FSA for expenses incurred during the applicable Plan Year and within the 2 ½ month grace period following the Plan Year (e.g., January 1 to March 15), or forfeit what remains. Your request for reimbursement (including complete claim supporting documentation) must be filed by April 15th after the Plan Year in which funds are allocated to your Health Care FSA for expenses incurred during that Plan Year and within the 2 ½ month grace period following the Plan Year. Any funds remaining in your account after that date will be forfeited.

With this "use or lose" rule, it is extremely important that you carefully plan your contributions to your Health Care FSA. Set aside only as much as you expect to claim during the Plan Year and within the 2 ½ month grace period following the Plan Year or you will lose it.

If you have incurred claims during the grace period, but have also elected to participate in the Health Care FSA for the following Plan Year, your claims will be reimbursed first from any balance remaining in your prior Plan Year account, and then from your current Plan Year account.

You may not use money in your Health Care FSA to pay dependent care expenses and vice versa. You may not switch money between the two accounts.

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Section 8. How the Day Care FSA Works

You can use the money in your Day Care FSA to pay for dependent care expenses (including care for an elderly or disabled dependent adult) you have during the year.

Here's how the account works:

- You decide how much to contribute to your Day Care FSA based on expenses you expect to incur during the year;
- Contributions are deducted from your pay on a pre-tax basis each pay period;
- When you incur an eligible expense, you submit a claim for reimbursement and,
- You will be reimbursed for the amount of your claim, up to the amount currently in your account.
- Dependent care expenses reimbursed through your Day Care FSA cannot be used in determining the federal dependent tax credit on your federal income tax return.

Contributions

The IRS limits the amount you may contribute to your Day Care FSA. There is an overall annual maximum of $5,000 (or $2,500 each if you and your spouse file separate income tax returns). But another limitation also applies. If you or your spouse earns less than the above amounts, the maximum contribution you can make is the lesser of your or your spouse's annual earnings.

For example: During 2013, Mary will earn $41,500 from her job. Her husband will earn $3,600 from his job. Mary's reimbursement from her Day Care FSA will be limited to $3,600. She can choose to contribute no more than $300 a month ($300 x 12 = $3,600) to her account.

For purposes of the IRS limit, your Spouse will have a presumed income if your Spouse is a full-time student or disabled and incapable of self-care. For each month that your Spouse is a full-time student or is incapacitated, your Spouse's income is presumed to be the greater of your spouse's actual income (if any) or $250. If you have two or more qualified dependents, the presumed income is the greater of your Spouse's actual income (if any) or $500 a month.

Eligible Expenses

Eligible expenses for reimbursement under the Plan include expenses incurred for the care of your qualified dependents:

- In your home,
- In another person's home,
- At a licensed nursery school, day camp (not overnight camp) or qualified day care center. A day care center will qualify if it meets state and local requirements and provides care and receives payment for more than 6 people who do not reside there, or
- At a specialty day camp (e.g., soccer camp, computer camp).

Expenses must be incurred in order to allow you, or if you are married, you and your spouse to work, or if your spouse is disabled and unable to care for him/herself or is a full-time student for at least 5 months of the year. To be eligible, expenses must have been incurred during the Plan Year and while you were covered under the Plan. An expense is considered incurred when the care or service is provided—not when your provider issues a bill, nor when you receive or pay that bill.

If the care is provided in your home or the home of another person, the care provider must not be claimed as a dependent on your tax return and must be age 19 or older (determined as of the close of the taxable year). An adult dependent must spend at least 8 hours a day in your home in order for expenses for caring for that person to be eligible. Services must be for the physical care of the child, not for education, meals, etc., unless incidental to the cost of care.

Ineligible Expenses

You cannot use the money in your Day Care FSA to pay for:

- General "baby-sitting" other than during work hours
- Care or services provided by:
    1. Your children under age 19 (whether or not they are your tax dependents)
    2. Anyone you (or your spouse if you are married) can claim as a dependent for federal income tax purposes
- Nursing home care
- Overnight camp
- Private school tuition
- Expenses for education (kindergarten and above)
- Expenses that would not otherwise be eligible to be credited on your federal income tax return
- The cost of transportation between the place where day care services are provided and your home unless such transportation is furnished by the dependent care provider
- Expenses incurred while you are off from work for any reason. However, if you pay your dependent care provider on a weekly or longer basis, dependent care expenses incurred during a temporary absence from work for illness or vacation may be eligible.
- Expenses for which you claim IRS child care credit when you file your tax return
- The IRS does not allow you to claim a credit for the same expenses on your income tax return for which you are reimbursed under the Flexible Spending Account

Claims Filing

Complete the claim form in full, and provide an itemized statement from your provider for work-related expenses. The itemized statements must include the provider's name and address, Social Security Number or Tax Identification Number (TIN), your dependent's name and age, as well as the specific dates daycare services were provided and the cost of care. The claim form can be used as an itemized statement if your daycare provider provides this information and signs the form where indicated. Cancelled checks cannot be accepted. Reimbursements can be made for services that have already been provided.

You must follow the claims filing procedures established by the Day Care FSA Plan Claims Administrator. See Appendix G.

You may also obtain a claim form from Sandia Corporate Forms or from Sandia Benefits at 505-844-HBES (4237).

In accordance with IRS regulations, amounts contributed to your Day Care FSA during the Plan year but remaining in your account at the end of the processing period (April 15 of the following year) cannot be returned to you or used to reimburse expenses incurred in a subsequent Plan year. These amounts are forfeited.

Use or Lose

It is important that you not contribute more than the dependent care expenses that you are sure to incur.

IRS regulations stipulate that you must use the full amount of money in your Day Care FSA for expenses incurred during the Plan Year or forfeit what remains. You must incur eligible expenses by December 31 in order for them to be eligible for reimbursement. Your request for reimbursement (including complete claim supporting documentation) must be filed by April 15 (postmarked date) after the Plan Year in which funds are allocated to your Day Care FSA account for expenses incurred during the Plan Year. Any funds remaining in your account after that date will be forfeited.

With this "use or lose" rule, it is extremely important that you carefully plan your contributions to your Day Care FSA. Set aside only as much as you expect to claim during the Plan Year or you will lose it.

You may not use money in your Day Care FSA to pay health care expenses and vice versa. You may not switch money between the two accounts.

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Section 9. Claims and Appeals Procedures

This section provides general information regarding claims and appeals procedures applicable to the Health Care FSA and Day Care FSA.

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

Upon written request and free of charge, a participant may examine documents relevant to his/her claim and submit opinions and comments. See Appendices C through G for the claims procedures for each FSA.

Benefits Payment

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

Participants cannot assign, pledge, borrow against, or otherwise promise any benefit payable under the Health Care FSA or Day Care FSA before receipt of that benefit. Your interest in your Health Care FSA or Day Care FSA is not subject to the claims of creditors. Exceptions include a QMCSO that requires a health plan to provide benefits to the employee's child.

On occasion, there are outstanding benefit payment checks that have been paid by a Claims Administrator but have not been cashed and have been stale-dated. In this case, the covered participant must notify the Claims Administrator or the Sandia Benefits Department within one calendar year from the end of the Plan Year in which the service was rendered to claim funds; otherwise the monies will be forfeited.

You may also obtain a claim form from Sandia Corporate Forms or from Sandia Benefits at 505-844-HBES (4237).

Timeframes for Initial Claims Decisions

After you submit your claim for reimbursement, the Claims Administrator, will decide if the claim is eligible for reimbursement typically within a reasonable time. The Claims Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide Spending Account claims.

The Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. Although the Day Care FSA is not subject to ERISA, the Claims Administrator will apply the same claims and appeals procedure as under the Health Care FSA. The Claims Administrator has the right to require such other evidence as it deems necessary in order to decide your claim. If the Claims Administrator denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

Contents of Notice and Response from the Claims Administrator

If your claim is denied in whole or in part, you will be notified in writing by the Claims Administrator within 30 days of the date the Claims Administrator received your claim. (This time period may be extended for an additional 15 days for matters beyond the control of the Claims Administrator, including in cases where a claim is incomplete.)

The Claims Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Claims Administrator is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information, and has the effect of suspending the time for a decision on your claim until the specified information is provided.

The notice of benefit determination will include all of the following:

- Specific reasons for the denial;
- References to the specific plan provisions upon which the denial is based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why that material or information is necessary;
- Description of the plan's appeal procedure and deadlines.
- A statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Decision on an appeal.
- If applicable, a copy of any rule, guideline, or protocol relied upon in making the Adverse Benefit determination, or a statement that the rule or guideline was relied upon and will be provided, upon request, free of charge;
- If an Adverse Benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the Adverse Benefit determination (or a statement that such explanation will be provided) free of charge upon request.

Filing an Appeal

IMPORTANT: Upon denial of a claim, you have 180 calendar days of receipt of the notification of Adverse Benefit determination to appeal the claim.

If a claim for benefits is denied in part or in whole, you have the right to appeal the claim. A request for further information (such as a diagnosis) from the provider of service is not a claim denial. You must exhaust the mandatory levels of appeals process before you can seek other legal recourse.

Timeframes for Appeals Decisions

Your appeal will be reviewed and decided by the Claims Administrator designated in the Plan in a reasonable time but no later than 60 days after the Claims Administrator receives your request for review.

Your Right to Information

If the appeal is denied, the notification will:

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

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

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

Eligibility or Mid-Year Election Change Appeal Procedures

You may use the eligibility or mid-year election change appeals procedure to request an informal review, a formal review, or both, if:

- You had a benefit claim that was denied by a Claims Administrator based solely on denied eligibility to participate or you are not enrolled, or
- You have been informed by the Benefits Department that you are not eligible for participation in the Health Care FSA or Day Care FSA because your mid-year election change was denied.

IMPORTANT: The deadline for submitting a request for an informal or formal review of your eligibility to the Benefits Department will be 180 days after you receive written notification of the denial of the claim or the denied eligibility or mid-year change by Sandia Benefits to enroll in the Health Care FSA or Day Care FSA Program. Once final resolution has been reached on your eligibility appeal by Sandia, you then have 180 days (from the date of the written notification by Sandia) to appeal your denied claim for benefits with the claim administrator.

Request for Informal Review

You have the option to request an informal review of your appeal for eligibility by contacting Sandia HBE at 505-844-HBES (4237). The Sandia Benefits Department will review all pertinent information and render a written decision as soon as possible but no later than fourteen (14) calendar days of the receipt of all material facts. If you are not satisfied with the decision of the Sandia Benefits Department, you can request a formal review.

Request for Formal Review

To request a formal review of a denial based solely on eligibility, you must submit an appeal in writing to the Secretary of the Employee Benefits Committee, c/o Benefits Department, PO Box 5800, Albuquerque, NM 87185, MS 1022. If the denied claim is based on any reason other than eligibility, you must file the appeal with the appropriate Claims Administrator listed in Appendix A. You will receive a response to your appeal within 60 calendar days of receipt of the appeal.

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

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

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

Note: The claimant may not submit a dispute regarding eligibility to a court with respect to a denied claim under the Sandia Flexible Spending Accounts Plan more than one hundred eighty (180) days after the date the Employee Benefits Claim Review Committee renders its final decision upon appeal.

Recovery of Excess Payment

The Claims Administrator has the right at any time to recover any amount paid by Sandia FSA Plan for covered charges in excess of the amount under the Sandia FSA Plan provisions.

IMPORTANT: By accepting benefits under the Sandia Flexible Spending Accounts, the covered participant agrees to reimburse payments made in error and cooperate in the recovery of excess payments.

Section 10. When Coverage Ends

This section outlines when coverage ends. See Section 11, Continuation of Group Health Coverage for specific rules governing how health coverage may be continued.

Health Care FSA and Day Care FSA participation ends on earliest of the:

- Last on roll day that the employee's leave of absence or termination of employment becomes effective, except as provided under temporary continuation of coverage under COBRA or otherwise provided by law or by the provisions of this Summary Plan Description.
- Date the Sandia FSA Plan is terminated.
- Last day the employee is no longer eligible as defined in the Section 3, Eligibility
- Last day of the pay period prior to the period in which any contributions are not paid when due (if applicable).
- Date of death.
- Submission of a fraudulent claim.

IMPORTANT: Health Care FSA may be continued in some situations. See Section 11, Continuation of Group Health Coverage for COBRA rules. Also, special rules apply to FMLA leaves of absence for family and medical care (see the Family and Medical Leave Act of 1993) and for military service (Uniformed Services Employment and Reemployment Rights Act of 1994).

Termination for Cause

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

- Abuse of Health Care FSA or Day Care FSA by providing false information on mid-year election change form, claim or substantiation documentation.
- Failure to comply with reimbursement rules.

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Section 11. Continuation of Group Health Coverage

This section outlines coverage options during a leave of absence, as well as the continuation of group Health Care FSA plan participation under COBRA in the event where you lose coverage under certain circumstances or during an unpaid absence.

Participation During Unpaid Non- FMLA Leaves of Absence

Day Care FSA
Upon taking an approved leave of absence, your contributions to the Day Care FSA will stop. Generally, expenses that you incur for dependent care when you are not working are ineligible for reimbursement. However, any expenses incurred for services rendered throughout the Plan Year so that you and your spouse can work, look for work, or attend school full time are eligible for reimbursement, up to the balance in your Day Care FSA.

If you return from an approved leave of absence within 30 calendar days after the start of a leave of absence, your participation in the Day Care FSA is automatically reinstated to the level of contributions that were elected at the beginning of the Plan Year. Your contributions will be automatically increased to make up any missed contributions during your leave of absence. However, if you experience a qualified change status event – for example, if your child has turned age 13 and his/her expenses are no longer eligible for reimbursement - you may be able to change your annual election.

If your leave of absence is 30 calendar days or more and you return from leave in the same Plan Year, you must reenroll and make a new election for the remainder of the Plan Year. You must enroll and make your new election within 30 calendar days after you return to work from a leave of absence using Sandia's HR Self-Service application. If you do not reenroll in the Day Care FSA within 30 calendar days after the date you return from a leave of absence, you cannot reinstate your coverage until the following Open Enrollment period generally each fall.

Health Care FSA
If you take a non-FMLA leave of absence, your Health Care FSA participation will stop after the end of your last pay period. If you lose Health Care FSA coverage as a result of your leave (due to a reduction in hours), you may be eligible to continue your coverage under COBRA.

If you return from an approved leave of absence within 30 calendar days after the start of a leave of absence, your participation in the Health Care FSA is automatically reinstated to the level of contributions that were elected at the beginning of the Plan Year. Your contributions will be automatically increased to make up any missed contributions during your leave of absence. However, if you experience a qualified change status event you may be able to make change your annual election.

If your leave of absence is 30 calendar days or more and you return from leave in the same Plan Year, you must reenroll and make a new election for the remainder of the Plan Year. You must make your new election within 30 calendar days after you return to work from a leave of absence using Sandia's HR Self-Service application. If you do not re-enroll in the Health Care FSA within 30 calendar days after the date you return from a leave of absence, you cannot reinstate your coverage until the following Open Enrollment period generally each fall.

Participation During FMLA Leaves of Absence

Day Care FSA
During a FMLA leave of absence, Day Care FSA participation is treated the same as during a non-FMLA leave. See the above description under Participation During Unpaid Non-FMLA Leaves of Absence.

Health Care FSA
If you take an FMLA leave of absence, you may continue your coverage under the Health Care FSA. If you are on a paid leave, your coverage will automatically continue. If you are on an unpaid FMLA leave of absence, you may pre-pay for the coverage before you go on leave or you may pay for your coverage on an after-tax basis during the leave. If you do not pay your contributions as required, your coverage for the period of the leave of absence will be canceled.

You also have the option to suspend your coverage under the Health Care FSA. Written notification to suspend coverage must be received by the Sandia Benefits Department, Attn: HBE, Mail Stop 1022, within 31 calendar days of the first day of the FMLA leave of absence.

If your Health Care FSA terminates during your leave of absence, your coverage will be reinstated if you return to work in the same Plan Year that your leave began. You will have a choice to resume contributions to the Health Care FSA at the same level in effect before your leave, or you may elect to increase your contributions to "make up" for contributions you missed during your leave period. If you simply resume your prior contribution level, the amount available for reimbursement for the year will be reduced by the contributions missed during your leave. Regardless of whether you choose to resume your former contribution level, or make up for missed contributions, expenses incurred while your Health Care FSA participation is suspended will not be reimbursed.

IMPORTANT: If you have exhausted your FMLA leave of absence and you terminate from Sandia, you may be eligible for continuation COBRA coverage.

Coverage through COBRA

COBRA coverage for the Health Care FSA, if elected, will consist of the Health Care FSA coverage in force at the time of the Qualifying Event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the Qualifying Event). The "use or lose" rule will continue to apply. All qualified beneficiaries who were covered under the Health Care FSA will be covered together for Health Care FSA COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate Health Care FSA annual coverage limit and a separate COBRA premium. Sandia's COBRA Administrator will send you a COBRA election notice explaining the procedure for continuing your participation under COBRA. If you don't receive this notice, please call HBE Customer Service at 505-844-HBES (4237).

If you have any questions, contact the UnitedHealthcare Benefit Services (UHCBS) Customer Care Center at 866-747-0048.

Section 12. Your Rights under ERISA

As a participant in the Health Care FSA, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

Continue Group Health Plan Coverage

Continue group health plan coverage for yourself, Spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court, after exhausting the plan's claims and appeals procedures. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court, after exhausting the plan's claims and appeals procedures.

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

Assistance with Your Questions

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

Section 13. Definitions

You can refer to this section as you read this document to have a clearer understanding of your benefits.

Term	Definition
Adverse Decision / Adverse Benefit	A denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a benefit.
Alternate Recipient	Child of a plan participant for whom coverage is required under a qualified medical child support order.
Claims Administrator	Refer to Appendix A
HBE	Health, Benefits, Compensation and Employee Services
Plan	Sandia Flexible Spending Accounts Plan
Qualifying Event	Under COBRA, an event that but for the COBRA requirements would result in the loss of coverage to a qualified beneficiary.
Spouse	Your lawful husband or wife as defined by federal law.

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Appendix A. Claims and Appeals Administrative Information

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

Program	Claims Administrator
Health Care FSA	
Applies to: • **UHC - Sandia Total Health Members**	United HealthCare Services, Inc. P.O. Box 981506 El Paso, TX 79998-1506 Fax: 915-231-1709 Toll free fax: 866-262-6354 Customer Service: 877-835-9855 www.myuhc.com
• **BCBSNM - Sandia Total Health Members**	Claims Department PO Box 400 Beltsville, Maryland 20704
Applies to: • **Kaiser –Sandia Total Health Members**	**Health Payment Services Claims Address:** Kaiser Permanente Health Account Services PO Box 1540 Fargo, ND 58107-1540 Phone: 1-877-750-3399 Fax: 1-877-535-0821 Email: kp@healthaccountservices.com
Day Care FSA	
Applies to: • **All Members**	**PayFlex Claims Address:** PayFlex™ Systems USA, Inc. P.O. Box 3039 Omaha, NE 68103 Fax: 402-231-4310 Telephone: 402-345-0666 800-284-4885 www.healthhub.com

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Appendix B. Plan Administration Information

What	Who
Official Plan Name	Sandia Flexible Spending Accounts Plan
Employer/Plan Sponsor	Sandia Corporation 1515 Eubank S.E. Albuquerque, NM 87123-1022
Employer I.D. Number (EIN)	85-0097942
Plan Number	565
Type of Plan	The Health Care Flexible Spending Account is a health plan under ERISA. The Day Care Flexible Spending Account is described in this SPD, it is not an ERISA plan.
Plan Funding Medium and Contributions	The benefits and other costs (such as administrative costs) for the Spending Account Plans are paid from the general assets of Sandia Corporation. Contributions are made by participating employees.
Plan Administrator	Sandia Corporation c/o Benefits Department Mailing address: 1515 Eubank S.E. Albuquerque, NM 87123-1022 OR P.O. Box 5800 Albuquerque, NM 87185-1022 (505) 844-5677
Claims Administrator	Refer to Appendix A of this document
Agent for Service of Legal Process	Corporation Service Company (CSC) 2711 Centerville Road, Suite 400 Wilmington, DE 19808 OR 125 Lincoln Avenue, Suite 223 Santa Fe, NM 87501 (505) 989-7500 OR 2730 Gateway Oaks Drive, #100 Sacramento, CA 95833 (916-641-5100)
Plan Year	January 1 – December 31
Contribution Sources	Participant contributions
Union Agreements	For represented employees, the Summary Plan Description reflects the Flexible Spending Accounts that have been and are currently subject to negotiations between Sandia and the various unions representing Sandia employees. Copies of collective bargaining agreements referring to the plans are distributed or made available to employees covered by such agreements and may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and are available for examination by participants and beneficiaries as described in the section entitled Your Rights Under ERISA of this Summary Plan Description. The effective date of the plans for employees in each bargaining unit is the date specified in the applicable union agreement.

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Appendix C. Applies to Sandia Total Health – UnitedHealthcare Participants

The content in this appendix is applicable to UnitedHealthcare processes. For detailed FSA benefit and plan information, please refer to chapters 1-13 of this Program Summary.

UnitedHealthcare will administer the Health Care Flexible Spending Account for participants enrolled in Sandia Total Health UnitedHealthcare. Beginning January 1, 2014, the FSA and HRA accounts will reimburse the same eligible expenses per IRS 213(d). You can find a listing of eligible expenses for reimbursement from the FSA and HRA on www.myuhc.com.

Claims Filing Process

A request for withdrawal form can be found on www.myuhc.com. However, if the automatic reimbursement (auto-rollover) feature as described in the Automatic Reimbursement (Auto-Rollover) section is turned "on" you will not have to submit a reimbursement form for certain Health Care FSA expenses.

Typically, a reimbursement form can be submitted as often as monthly; however, if reimbursement forms are submitted more frequently, they will not be rejected. You will be reimbursed for eligible expenses as long as the amount requested for reimbursement does not exceed your annual FSA election amount, or the available amount from your HRA."

If the automatic reimbursement (auto-rollover) feature as described in the Automatic Reimbursement (Auto-Rollover) section is turned "on" you will not have to submit a reimbursement form for certain Health Care FSA expenses.

Claims Filing Process with a Health Care FSA and/or HRA

Refer to the *Sandia Total Health administered by UnitedHealthcare Program Summary* for detailed information about the HRA.

Generally, UHC in-network providers will not collect a payment at the time of service. The provider will bill UHC and UHC will process your claim.

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

The Health Care FSA and HRA will only pay if you have funds available.

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

IMPORTANT: You cannot be reimbursed from more than one tax-advantaged plan (e.g. Health Care FSA and HRA) for any single expense. Refer to the Overpayment Procedures section for more information.

Medical Expenses

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

If you see an in-network provider:

1. The provider will file a medical claim with UHC.
2. If the service requires the Deductible or Coinsurance, UHC will look to see if you have funds in your Health Care FSA first, then your HRA.
    a. If you do, UHC will pull your share of the cost of the service from your Health Care FSA and/or HRA.
    b. Health Care FSA/HRA funds are paid directly to the provider.
3. Once your UHC claim is processed, all claim and Health Care FSA and/or HRA activity will be documented and sent to you on your UHC Health Statement. Additionally, if the funds come from your Health Care FSA you will receive an Explanation of Benefits (EOB) as well.
4. Review this statement for accuracy and contact UHC if you believe there are errors.

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

1. You are responsible for filing the medical claim with UHC.
2. If the service requires the Deductible or Coinsurance, UHC will look to see if you have funds in your Health Care FSA first, then your HRA.
    a. If you do, UHC will pull your share of the cost of the service from your Health Care FSA and/or HRA.
    b. Health Care FSA and HRA funds will be paid directly to you.
3. Once your UHC claim is processed, all claim and Health Care FSA and/or HRA activity will be documented and sent to you on your UHC Health Statement. Additionally, if the funds come from your Health Care FSA you will receive an Explanation of Benefits (EOB) as well.
4. Review this statement for accuracy and contact UHC if you believe there are errors.

Prescription Drugs

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

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

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

Special Note Regarding Orthodontia Claims Processing

Orthodontia claims require an itemized statement/paid receipt. Reimbursements can be made in one lump sum.

- Coupon Payment Option – You can submit an itemized statement of your orthodontia expenses as the service is provided. Submit this documentation with a completed claim form for reimbursement.
- Total Payment Option – If you paid the entire amount of treatment when the service began, attach to the claim form a copy of your paid receipt, along with an itemized statement showing the provider name, patient name, date treatment started, dollar amount and amount insurance will pay. Under this option, you can only file this expense once. You cannot submit this expense again in future plan years.

Setting up Direct Deposit

To set-up direct deposit:

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

IMPORTANT: Myuhc.com includes many features such as the options to:

- View Explanation of Benefits/Health Statements
- Utilize a savings calculator for FSA
- View your FSA summary page detailing contributions and balance of Health Care FSA dollars left in your FSA
- View your FSA Claims Summary including claim transaction details

Automatic Reimbursement (Auto-Rollover)

Your employer has elected to have eligible expenses for medical claims which are not covered under your UnitedHealthcare administered medical plan automatically submitted to your Health Care FSA for reimbursement. This eliminates extra paperwork and makes it more convenient for you to use your Health Care FSA. Automatic Reimbursement (Auto-rollover) is turned "on" at the start of the Plan year. You can turn automatic reimbursement (auto-rollover) of claims "off" or back "on" by going on to www.myuhc.com. All claims must still be verified and UnitedHealthcare may request additional substantiation.

In addition, if you have pharmacy, dental and/or vision coverage, the automatic reimbursement (auto-rollover) feature does not apply.

IMPORTANT: If you cover a domestic partner under your UnitedHealthcare administered medical plan that is not your federal tax dependent for health coverage purposes you should turn-off the Automatic Reimbursement feature by going to www.myuhc.com to avoid taxable health care transactions.

An FSA withdrawal request must be submitted for expenses that are not filed to your Health Care FSA with the Auto-rollover or if you did not use the Health Care Spending MasterCard. .

Turning off the auto-rollover feature if you have both a Health Care FSA/HRA

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

1. In-network medical providers submit paperless claims directly to UHC
2. Swipe your UHC Health Care Spending MasterCard for pharmacy orders and (for Health Care FSA) non-covered medical expenses (e.g., dental and vision) at an IIAS-certified merchant. For a complete list of participating merchants that are currently IIAS-certified, visit www.SIG-IS.org and select Merchant List.
3. Submit a manual claim to pay the employee for Health Care FSA and/or HRA claims. All manual claims are paid to the employee. If you have turned off the auto-rollover payment, you will need to file all claims manually or use your UHC Healthcare Spending MasterCard Debit card.
4. Manually pay claims to the provider with UHC's myClaims Manager at www.myuhc.com.

You can download the claim form, view your account balance, and access other useful account information on www.myuhc.com.

If you expect to have unused Health Care FSA dollars in your 2013 HealthCare FSA and plan to use the "grace period" for reimbursement for unused funds to avoid "double dipping," OR you would like to hold on to your Health Care FSA funds to pay for other eligible expenses during the year, other than medical, (e.g., dental and vision expenses) - you can log on to www.myuhc.com where you discontinue the automatic payment of your HRA and Health Care FSA/HRA until the rollover funds are used:

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

IMPORTANT: If you select to only discontinue the Health Care FSA, please note that you must also discontinue the HRA. A member may not override the payment hierarchy of Health Care FSA pays first then HRA pays second.

Note: Once you have filed your grace period claims with UHC PayFlex (allowed through March 15), you will need to go back and "turn-on" the automatic payment options. If you do not turn-on the automatic payment option, you will need to submit paper claims for payment from your 2013 Health Care FSA/HRA funds.

If you turn off the auto-pay feature, you can still use your debit card to access your Health Care FSA/HRA funds.

UHC Health Care Spending MasterCard

You will be provided with a UHC Health Care Spending MasterCard that may be used to pay for certain eligible expenses directly from your Health Care FSA. The UHC Health Care Spending MasterCard allows for direct payment to qualified locations and providers and can be used at any approved location that accepts MasterCard®. Use of the UHC Health Care Spending MasterCard is voluntary.

IMPORTANT: You should familiarize yourself with the specific products and services that are eligible for card use based on this Plan. Go to www.myuhc.com to learn how to get the most out of your UHC Health Care Spending MasterCard.

UHC will issue you a debit card called the UHC Health Care Spending MasterCard (debit card). Two cards are sent for convenience. The debit cards are issued with the Primary Covered Member's name, however any covered member can use them. If you choose to activate the Health Care Spending Card Debit MasterCard® you will need to call the toll-free number indicated on the sticker affixed to the card and follow the voice prompts to activate. The card will be ready to use with funds available real time upon activation of the card within the first Plan year. However, for future Plan years the funds will not be available for use until the effective date of the future Plan year.

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

This debit card can be used for paying eligible 213 (d) expenses.

Qualified Locations and Providers

The UHC Health Care Spending MasterCard may be used at any approved provider or merchant with a Point-of-Service (POS) bankcard terminal that accepts MasterCard® or your UHC Health Care Spending MasterCard number can be entered online or on an order form, similar to using a credit card number. You can even use your UHC Health Care Spending MasterCard to pay for a bill you receive in the mail if the merchant or provider accepts MasterCard®. Examples of qualified locations and providers include hospitals, physician and dental offices, vision care providers, and retail pharmacy counters.

Additionally, your UHC Health Care Spending MasterCard can be used at Walgreen's retail stores or at participating retailers as described in the Retailers with Inventory Information Approval System (IIAS) section.

Using the UHC Health Care Spending MasterCard

In order to use the UHC Health Care Spending MasterCard, you will need to enter 'credit' on the POS bankcard terminal just as if you were purchasing an item using a credit card. Each time the card is used for payment, you will sign a receipt. Your FSA and card are regulated by the IRS, therefore you should retain all itemized receipts generated from the UHC Health Care Spending MasterCard, because certain payments must be verified and UnitedHealthcare may request this receipt from you to ensure that payment was made for a qualified health care expense. Credit card receipts that do not itemize expenses are not sufficient to verify payment. Amounts paid that cannot be verified may be considered taxable income to you.

Once you swipe the UHC Health Care Spending MasterCard through the POS bankcard terminal, your available benefit balance is verified. The card validates your purchases real-time and automatically debits

your FSA account based on the guidelines established by the IRS and your specific plan design as described under Sections 7 and 8. A claim number is assigned to the transaction.

Partial Payment Authorization

Partial authorization capability allows you to use your UHC Health Care Spending MasterCard with transactions amounts greater than the funds available in your Health Care FSA for a portion of the transaction at providers or merchants that accept partial authorization. For example, if you purchase an item that costs $20 and you only have $10 remaining in your Health Care FSA, the Health Care FSA balance of $10 will be authorized towards the purchase and you are responsible for paying the remaining balance of $10 with another form of payment.

Note: Not all providers or merchants accept partial authorization.

Retailers with Inventory Information Approval System (IIAS)

IRS regulations require that retailers comply with IRS Inventory Information Approval System (IIAS) swipe technology as a method to identify and substantiate eligible health care expenses, per Section 213(d) of the Internal Revenue Code. The IIAS allows you to use your UHC Health Care Spending MasterCard to pay for 213(d) eligible health care expenses without having to provide any additional documentation or request reimbursement after a purchase is made, as transactions will be verified at the point of sale and payment will be made right from your Health Care FSA. Additionally, IIAS compatibility allows you to use your UHC Health Care Spending MasterCard at participating retailers to pay for both ineligible expenses and eligible health care expenses on the same transaction with eligible health care expenses being approved via the UHC Health Care Spending MasterCard and remaining ineligible expenses may be paid using another form of payment. When you use your card at participating retailers, eligible health care expenses will be identified and noted on your receipt. You will not have to submit receipts for reimbursement as long as the purchases are made at a participating retailer and you use your UHC Health Care Spending MasterCard. IRS guidelines still require you to save your itemized receipts as part of your tax records. You can see a full list of participating retailers at www.sig-is.org. If you go to a non-participating retailer you can still buy eligible health care expenses that don't provide itemized sales receipts, however you will need to pay using another form of payment, and then submit receipts for reimbursement as described in the Claims Filing Process section.

Monthly Health Statements and FSA Yearly Statements

Explanation of Benefits (EOBs) will not be issued for card transactions. Instead, you will receive monthly health statements and a FSA yearly statement which will include your card activity. You will also be able to view card transactions on www.myuhc.com. If you note a discrepancy on the monthly health statement or FSA yearly statement, call the number on the back of your UHC Health Care Spending MasterCard to resolve the issue.

Overpayment Procedures

It is possible, although not common, to have a negative balance in your Health Care FSA account. The transaction information for the Health Spending Account Card is updated daily. However, there could be an instance when the card is used on the same day a manual/auto-rollover claim is received and the total amount of both services results in a negative balance in the account. If this occurs, you should notify UHC customer Care at 1-877-835-9588 and UHC will advise you of the overpayment procedures to begin the *recoupment process.*

Contacting Customer Care

Call our toll-free number at 1-877-835-9855 available 24 hours a day.

- Order Additional cards
- Report a lost or stolen card
- Get answers concerning eligible expenses or your account balances

Claim Denials and Appeals

If Your Claim is Denied

If a claim for benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your UHC Health Care Spending MasterCard card before requesting a formal appeal. UnitedHealthcare will try to resolve the issue over the phone, however, if you are not satisfied you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

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

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of service;
- the reason you think your claim should be paid; and
- any documentation or other written information to support your request.

You or your Dependent may send a written request for an appeal to:

UnitedHealthcare – Appeals
Attn. Appeals
P.O. Box 981512
El Paso, TX 79998-1512

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by an appropriate individual(s) who did not make the initial benefit determination. Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Appendix D. Applies to Sandia Total Health – Blue Cross and Blue Shield of New Mexico Participants

The content in this appendix is applicable to Blue Cross and Blue Shield of New Mexico processes. For detailed FSA benefit and plan information, please refer to chapters 1-13 of this Program Summary.

ConnectYourCare LLC. will administer the Health Care Flexible Spending Account for participants enrolled in Sandia Total Health BCBSNM. ConnectYourCare LLC will administer the HRA for participants enrolled in Sandia Total Health BCBSNM.

Claims Filing Process with a Health Care FSA and/or HRA

Generally, Sandia Health Partner Network (SHPN) and BCBSNM in-network providers will not collect a payment at the time of service. The provider will bill BCBSNM directly; BCBSNM will then process the medical expense as a claim.

To this end, BCBSNM reviews the medical service, makes certain that it is covered by the STH plan, and then determines the "allowable" amount, i.e. the amount to reimburse the provider, which is usually less than the billed amount. Then, BCBSNM determines the portion owed by the plan, i.e. Sandia, as well as the member portion, i.e. the out-of-pocket amount.

Once BCBSNM determines the member out-of-pocket amount, BCBSNM submits the claim to ConnectYourCare to determine if the member has first any available Health Care FSA funds and secondly, any available HRA funds. If either set of funds is available, ConnectYourCare pays the provider directly from first the HC FSA and then the HRA. Once both the HC FSA and HRA are depleted, the member is responsible for paying the remaining amount of his/her balance directly to the provider.

If you are using an out-of-network provider, the provider may require payment at the time of service.

Refer to the *Sandia Total Health administered by Blue Cross and Blue Shield of New Mexico Program Summary* for detailed information about the HRA.

You can keep track of the dollars in your Health Care FSA and HRA by going to www.connectyourcare.com , emailing via service@connectyourcare.com or contacting customer service at 1-877-891-1022.

IMPORTANT: You cannot be reimbursed from more than one tax-advantaged plan (e.g. HRA and HC FSA) for any single expense.

Auto-Pay On or Off

You have the option to turn Auto-Pay on or off for your FSA and HRA accounts; however, this option does not allow you to leave Auto-Pay on for one of the two accounts, either HC FSA or HRA.
That means if you choose to turn-off Auto-Pay, then neither your HC FSA nor your HRA will auto-pay. The Auto-Pay option does not give you the choice to only turn off only one account if you have FSA and HRA funds.

When the auto-pay setting is turned off for your FSA and HRA accounts, you can "Click-to-Pay" the claims of your choice. This gives you the convenience of choosing how you want to spend your dollars and whether you want to make a partial payment.

How To Use Click-to-Pay:

1. Log into www.ConnectYourCare.com
2. Click "Health Plan Claims" under "Claim Center" in the Quick Links section of the home page.
3. You can choose whether to turn Auto-Pay on or off. If Auto-Pay is on, all claims will be reimbursed automatically by paying first from your FSA, if enrolled, and second from your HRA. This setting can be changed at any time. If Auto-Pay is off, claims that are ready to be paid will display prominently on the Home page. To pay these claims, simply click on the desired claim to view the claim details.
    a. Decide to pay or not pay the claim, and the amount to pay. Claims not paid immediately can be filed for future payment.
    b. Review and confirm payment. The payment reimbursement will be issued to the participant for non-medical claims. For SHPN and BCBSNM in-network medical providers, reimbursement will be paid directly to the provider.

Note: Regardless of the status of your Auto-Pay function, all claims for medical and non-medical 213(d) items will pay first from your HC FSA, if enrolled, and second from your HRA.

Dental Claims

Dental are electronically filed from Delta Dental to ConnectYourCare. ConnectYourCare will reimburse you from your FSA funds (if any) until they are depleted and then from your HRA funds until they are depleted.

Special Note regarding Orthodontia Claim Processing

Orthodontia claims require an itemized statement/paid receipt, the orthodontist's contract/payment agreement, or monthly payment coupons. Reimbursements can be made in one lump sum, or as the services are provided over the expected treatment period.

- Coupon Payment Option – You can submit an itemized statement of your orthodontia expenses as the service is provided. Submit this documentation with a completed claim form for reimbursement.
- Monthly Payment Option – You can obtain a contract agreement from the orthodontist showing the patient name, the date of service begins and the length of service, charges for the initial banding work and the dollar amount charged each month. Submit this with your first claim form and we can automatically reimburse you each month, according to the contract. This eliminates

the need for you to send a claim form each month. You do need to send a new claim form with your contract agreement at the beginning of the next plan year if you wish to continue.

- Total Payment Option – If you paid the entire amount of treatment when the service began, attach to the claim form a copy of your paid receipt, along with an itemized statement showing the provider name, patient name, date treatment started, dollar amount and amount insurance will pay. Under this option, you can only file this expense once. You cannot submit this expense again in future plan years.

Prescription Drug Claims

The Sandia Total Health BCBSNM plan pays first from your HC FSA and then from your HRA. This hierarchy cannot be altered. If you wish to be reimbursed for eligible out-of-pocket prescription drug expenses, the following steps must occur:

- You may use your Sandia ConnectYourCare debit card to pay for your out-of-pocket prescription costs.

1. You may also submit your claim by using a ConnectYourCare claim form or by entering your claim on to the Connect Your Care member portal by logging on to www.connectyourcare.com. These funds will be reimbursed to you directly.
    - If FSA funds are depleted, BCBSNM will then pay you directly from your HRA funds (if any remain).

Other Health Care FSA and HRA-Eligible Claims

All other eligible expenses for HC FSA and HRA reimbursement such as dental, vision, hearing and other eligible FSA and HRA expenses may be filed for reimbursement from your FSA and HRA.

You may use your ConnectYourCare debit care to pay for prescriptions, dental, vision and hearing expenses only. You may not pay for medical expenses with your debit card.

If you wish to file your claims with ConnectYourCare

- Complete a ConnectYourCare FSA claim form and submit it to Connect Your Care via the following methods:

1. Email to service@connectyourcare.com
    - Mail Claims to:

      Claims Department
      PO Box 400
      Beltsville, Maryland 20704
- Enter your claims information and upload appropriate documentation electronically via the customer portal at www.connectyourcare.com

BCBSNM

Each time BCBSNM processes a claim, it forwards the claim electronically to ConnectYourCare. The claim appears in your online healthcare account. Your owed portion will be reimbursed to your provider directly first from your FSA account, if you are enrolled and funds are available; and then, from your HRA if funds are available.

Contact Information

BCBSNM
P.O. Box 27630
Albuquerque, NM 87125-7630
www.bcbsnm.com/sandia
877-498-7652 (SNLB)

Claim Denials and Appeals

If Your Claim is Denied for Medical Benefits

If a medical claim for benefits is denied in part or in whole, you may call BCBSNM before requesting a formal appeal. BCBSNM will try to resolve the issue over the phone; however, if you are not satisfied, you have the right to file a formal appeal with BCBSNM as described below.

Upon denial of a claim, dissatisfaction with the way a claim is paid, or the denial of a request for service, you have 180 calendar days of receipt of the notification of Adverse Benefit Determination to appeal the claim. You must exhaust the appeals process before you can seek other legal recourse.

Before requesting a formal appeal, you may informally contact the claims administrator's Customer Service at 877-498-7652. If the Customer Service Advocate cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing at the address noted below (you may also call Customer Service and ask for assistance with your appeal). However, if you are not satisfied with a claim determination, you may appeal it as described below, without first informally contacting Customer Service.

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

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

You, your authorized representative (if you want someone to represent you in the appeal process, you must submit written authorization to BCBSNM designating the name of the person) or your doctor, can send the written appeal to:

Medical/Behavioral Health Appeals to:

BCBSNM Appeals Unit
PO Box 27630
Albuquerque, NM 87125-9815

Phone: 800-205-9926
Fax: 505 962 7541

Once the review is complete, if BCBSNM upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

If your claim is denied for Health Care FSA reimbursement

If a Health Care FSA reimbursement claim was denied in part or in whole, you may call ConnectYourCare before requesting a formal appeal. ConnectYourCare will try to resolve the issue over the phone; however, if you are not satisfied, you have the right to file a formal appeal with ConnectYourCare as described below.

If a participant's claim is denied in whole or in part, the participant has the right to appeal a denied claim if they are not satisfied with the outcome of the initial decision. They are instructed to send the appeal in writing to ConnectYourCare within 180 days of the initial claim denial. The address they should send the claim appeal to is:

Claims Appeal Department
307 International Circle, Ste 200
Hunt Valley, MD 21030

The review will be by a person who was neither involved in the initial determination nor a subordinate of that person and also will not defer to the initial determination. It will take into account all comments, documents, records, and other information submitted by you, without regard to whether that information was submitted or considered in the initial benefit determination. You will be provided at no charge upon request all documents relevant to your claim. Your appeal will be reviewed within 60 days of receipt and you will be provided with a written explanation of the benefit action under section 502(a) of ERISA.

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Appendix E. Applies to Sandia Total Health – Kaiser Permanente Participants

The content in this appendix is applicable to Kaiser Permanente Health Payment Services process. For detailed FSA benefit and plan information, please refer to chapters 1-13 of this Program Summary.

Kaiser Health Payment Services will administer the Health Care Flexible Spending Account (FSA) and Health Reimbursement Account (HRA) for participants enrolled in Sandia Total Health Kaiser Permanente.

Claims Filing Process

After you incur an eligible expense and don't use your debit card, you have the option of submitting a claim online at www.kp.org/healthpayment or completing a paper claim form and mailing or faxing it along with itemized documentation to Health Payment Services. Claims may be submitted anytime.

If you have established a Health Care FSA, your total annual contribution amount is available immediately. You can use your Kaiser Health Payment Card or request reimbursement for eligible expenses up to your annual contribution amount as soon as such eligible expenses have been incurred.

Claims Filing Process with a Health Care FSA and/or HRA

Refer to the *Sandia Total Health administered by Kaiser Permanente Program Summary* for detailed information about the HRA.

Generally, Kaiser in-network providers will collect a payment at the time of service. In this case you may want to use your Kaiser Health Payment Card to make the payment. Remember that only the amount available in the Health Care FSA and HRA may be paid with your Kaiser Health Payment Card.

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

The Health Care FSA and HRA will only pay if you have funds available.

You can keep track of the dollars in your Health Care FSA and HRA by going to www.kp.org/healthpayment or by calling 1-877-750-3399.

IMPORTANT: You cannot be reimbursed from more than one tax-advantaged plan (e.g. Health Care FSA and HRA) for any single expense. Refer to the Overpayment Procedures section for more information.

Special Note regarding Orthodontia Claims Processing

Orthodontia claims require an itemized statement/paid receipt, the orthodontist's contract/payment agreement, or monthly payment coupons. Reimbursements can be made in one lump sum, or as the services are provided over the expected treatment period.

- Coupon Payment Option – You can submit an itemized statement of your orthodontia expenses as the service is provided. Submit this documentation with a completed claim form for reimbursement.

- Monthly Payment Option – You can obtain a contract agreement from the orthodontist showing the patient name, the date of service begins and the length of service, charges for the initial banding work and the dollar amount charged each month. Submit this with your first claim form and we can automatically reimburse you each month, according to the contract. This eliminates the need for you to send a claim form each month. You do need to send a new claim form with your contract agreement at the beginning of the next plan year if you wish to continue.

- Total Payment Option – If you paid the entire amount of treatment when the service began, attach to the claim form a copy of your paid receipt, along with an itemized statement showing the provider name, patient name, date treatment started, dollar amount and amount insurance will pay. Under this option, you can only file this expense once. You cannot submit this expense again in future plan years.

Options for Reimbursement

Submitting on-line at www.kp.org/healthpayment

Fax in a claim form with the itemized receipts to 1-877-535-0821.

Mail in a claim form with the itemized receipts to:

Kaiser Permanente
Health Account Services
PO Box 1540
Fargo, ND 58107-1540

Kaiser Health Payment Card

You will be provided with a Kaiser Health Payment Card that may be used to pay for certain eligible expenses directly from your Health Care FSA. The Kaiser Health Payment Card allows for direct payment to qualified merchant locations where Visa® is accepted. Use of the Kaiser Health Payment Card is voluntary.

IMPORTANT: You should familiarize yourself with the specific products and services that are eligible for card use based on this Plan.

Receiving Your PayFlex Card

Your Kaiser Health Payment Card will be mailed directly to your home address and will arrive in a plain white envelope, so please do not confuse it with junk mail. Read the terms and conditions found on the card insert and sign the back of your card. You may call the customer service number listed on the back of the card to order additional cards.

Activating Your PayFlex Card

No action is required to activate the card. The card will be ready to use when it is received.

Qualified Locations and Providers

You can use the card at qualifying merchant locations that accept Visa. This includes places such as physician and dental offices, pharmacies and vision providers.

Using the Kaiser Health Payment Card

The Kaiser Health Payment Card is to be used for qualified healthcare expenses. When you use the card for purchasing healthcare related items, your healthcare account is automatically debited to pay for eligible expenses.

The Kaiser Health Payment Card allows you to pay for eligible expenses at the point of service. Participants using the Kaiser Health Payment Card take advantage of five key benefits:

- Immediate payment of your expenses from your healthcare account
- Auto-substantiated claims when used at a Kaiser Permanente facility/hospital
- Increases your personal cash flow
- Reduces paper claim filing
- Ease of use of your pre-tax funds

The Kaiser Health Payment Card is a great tool to help relieve some of your paperwork; however it is important that you keep all itemized documentation for the entire plan year in the event the purchase substantiation information is requested by Kaiser Permanente, in order to comply with IRS regulations.

How does the Kaiser Health Payment Card work?

As you incur eligible healthcare expenses, you present your Kaiser Health Payment Card for payment. If you are purchasing services or items from a healthcare-related merchant or one that has implemented an inventory information approval system, your transaction will be automatically validated at the point of sale. You should always retain documentation of your expenses in the event that you need to provide to the IRS. Documentation includes an itemized receipt listing the merchant name, name of the item/product, date of purchase and amount.

The card is valid for a three year period and will contain information regarding your current plan year election. Each year when you re-enroll, the card will reflect that plan year election amount(s). The card

can only be used for expenses incurred during the plan year and during the grace period. The grace period was a benefit feature elected by Sandia, which allows an extra2 ½ month period to utilize your FSA dollars.

Retailers with Inventory Information Approval System (IIAS)

The Kaiser Health Payment Card is accepted at all healthcare-related merchants, such as physician and dentist offices, hospitals, pharmacies, hearing and vision care providers. The card will also work at discount stores and grocery stores that have implemented an inventory information approval system (IIAS). The IIAS only allows eligible expenses to be purchased at these merchants.

Overpayment Procedures

It is possible, although not common, to have a negative balance in your Health Care FSA account. The transaction information for the Kaiser Health Payment Card is updated daily. However, there could be an instance when the card is used on the same day a manual/auto-rollover claim is received and the total amount of both services results in a negative balance in the account. If this occurs, you should notify Kaiser Health Payment Services at 1-877-750-3399. Kaiser Health Payment Services will advise you of the overpayment procedures to begin the *recoupment process*.

Contacting Kaiser Health Payment Services

Kaiser Permanente
Health Account Services
PO Box 1540
Fargo, ND 58107-1540
Phone: 1-877-750-3399
Fax: 1-877-535-0821
Email: kp@healthaccountservices.com

7:00 am – 9:00 pm CST, M-F

Claim Denials and Appeals

If Your Claim is Denied

If a claim for benefits is denied in part or in whole, you may call Kaiser Health Payment Services before requesting a formal appeal Kaiser Health Payment Services will try to resolve the issue over the phone; however, if you are not satisfied, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

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

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of service;
- the reason you think your claim should be paid; and

- any documentation or other written information to support your request.

You or your Dependent may send a written request for an appeal to:

Kaiser Permanente
Health Account Services
Attention: Appeals

PO Box 1540
Fargo, ND 58107-1540

Review of an Appeal

Kaiser Health Payment Services will conduct a full and fair review of your appeal. The appeal may be reviewed by an appropriate individual(s) who did not make the initial benefit determination. Once the review is complete, if Kaiser Health Payment Services upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Appendix F. Applies to Employees not participating in the Sandia Total Health Plan

The content in this appendix is applicable to PayFlex Systems USA, Inc. processes. For detailed FSA benefit and plan information, please refer to chapters 1-13 of this Program Summary.

PayFlex Systems USA, Inc. will administer the Health Care Flexible Spending Account for employees not enrolled in the Sandia Total Health Plan.

Claims Filing Process

After you incur an eligible expense, you have the option of submitting a claim online using **Express Claims** or completing a paper claim form and mailing or faxing it along with itemized documentation to PayFlex. Claims may be submitted anytime.

If you have established a Health Care FSA, your total annual contribution amount is available immediately. You can request reimbursement for eligible expenses up to your annual contribution amount as soon as such eligible expenses have been incurred.

Claims Filing Process with a Health Care FSA

Generally, in-network providers will collect a 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 Health Care FSA may be paid with the debit card.

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

The Health Care FSA will only pay if you have funds available.

You can keep track of the dollars in your Health Care FSA by going to www.healthhub.com, or by calling PayFlex at 800-284-4885.

IMPORTANT: You cannot be reimbursed from more than one tax-advantaged plan (e.g. Health Care FSA and HRA) for any single expense. Refer to the Overpayment Procedures section for more information.

Special Note regarding Orthodontia Claim Processing

Orthodontia claims require an itemized statement/paid receipt, the orthodontist's contract/payment agreement, or monthly payment coupons. Reimbursements can be made in one lump sum, or as the services are provided over the expected treatment period.

- Coupon Payment Option – You can submit an itemized statement of your orthodontia expenses as the service is provided. Submit this documentation with a completed claim form for reimbursement.
- Monthly Payment Option – You can obtain a contract agreement from the orthodontist showing the patient name, the date of service begins and the length of service, charges for the initial banding work and the dollar amount charged each month. Submit this with your first claim form and we can automatically reimburse you each month, according to the contract. This eliminates the need for you to send a claim form each month. You do need to send a new claim form with your contract agreement at the beginning of the next plan year if you wish to continue.
- Total Payment Option – If you paid the entire amount of treatment when the service began, attach to the claim form a copy of your paid receipt, along with an itemized statement showing the provider name, patient name, date treatment started, dollar amount and amount insurance will pay. Under this option, you can only file this expense once. You cannot submit this expense again in future plan years.

Options for Reimbursement

Submitting an Express Claims on-line at www.healthhub.com:

Fax in a claim form with the itemized receipts to 402-231-4310.

Mail in a claim form with the itemized receipts to:

PayFlex Systems USA, Inc.
P.O. Box 3039
Omaha, NE 68103-3039

If you have enrolled in e-Notify, you will receive an email once your claim has been processed.

PayFlex™ Card

You will be provided with a PayFlex Card that may be used to pay for certain eligible expenses directly from your Health Care FSA. The PayFlex Card allows for direct payment to qualified merchant locations where MasterCard® is accepted. Use of the PayFlex Card is voluntary.

IMPORTANT: You should familiarize yourself with the specific products and services that are eligible for card use based on this Plan. Go to www.healthhub.com to learn how to get the most out of your PayFlex Card.

Receiving Your PayFlex Card

Your PayFlex Card will be mailed directly to your home address and will arrive in a plain white envelope, so please do not confuse it with junk mail. Read the terms and conditions found on the card insert and sign the back of your card. You may call the customer service number listed on the back of the card to order additional cards.

Activating Your PayFlex Card

Instructions to activate your card and establish a PIN will arrive with your card, please follow the instructions, as activation is now required.

Qualified Locations and Providers

You can use the card at qualifying merchant locations that accept MasterCard. This includes places such as physician and dental offices, pharmacies and vision providers. Over 98 percent of all healthcare merchants accept the PayFlex Card.

Using the PayFlex Card

The PayFlex Card is to be used for qualified healthcare expenses. When you use the card for purchasing healthcare related items, your healthcare account is automatically debited to pay for eligible expenses.

The PayFlex Card allows you to pay for eligible expenses at the point of service. Participants using the PayFlex Card take advantage of four key benefits:

- Immediate payment of your expenses from your healthcare account
- Increases your personal cash flow
- Reduces paper claim filing
- Ease of use of your pre-tax funds

The PayFlex Card is a great tool to help relieve some of your paperwork; however it is important that you keep all itemized documentation for the entire plan year in the event the purchase substantiation information is requested by PayFlex, in order to comply with IRS regulations.

How does the PayFlex Card work?

As you incur eligible healthcare expenses, you present your PayFlex Card for payment. If you are purchasing services or items from a healthcare-related merchant or one that has implemented an inventory information approval system, your transaction will be automatically validated at the point of sale. You should always retain documentation of your expenses in the event that you need to provide it to the IRS. Documentation includes an itemized receipt listing the merchant name, name of the item/product, date of purchase and amount. If you purchase a prescription drug along with non-qualifying items, be sure to ask the merchant to ring up the prescription separately so that you can use the card.

The card is valid for a five year period and will contain information regarding your current plan year election. Each year when you re-enroll, the card will reflect that plan year election amount(s). The card can only be used for expenses incurred during the plan year, unless your employer has elected the grace period, allowing an extra 2 ½ month period to utilize your FSA dollars.

Retailers with Inventory Information Approval System (IIAS)

The PayFlex Card is accepted at all healthcare-related merchants, such as physician and dentist offices, hospitals, pharmacies, hearing and vision care providers. The card will also work at discount stores and grocery stores that have implemented an inventory information approval system (IIAS). The IIAS only allows eligible expenses to be purchased at these merchants. To view a listing of IIAS approved merchants and a listing of eligible and ineligible expense items go to www.healthhub.com.

Overpayment Procedures

It is possible, although not common, to have a negative balance in your Health Care FSA account. The transaction information for the PayFlex Card is updated daily. However, there could be an instance when the card is used on the same day a manual/auto-rollover claim is received and the total amount of both services results in a negative balance in the account. If this occurs, you should notify PayFlex at 1-800-284-4885. PayFlex will advise you of the overpayment procedures to begin the *recoupment process.*

Contacting PayFlex

PayFlex Systems USA, Inc.
P.O. Box 3039
Omaha, NE 68103-3039
www.healthhub.com
800-284-4885 (phone)
402-231-4310 (fax)
Monday – Friday, 7:00 a.m. – 7:00 p.m. CT
Saturday, 9:00 a.m. – 2:00 p.m. CT

Claim Denials and Appeals

If Your Claim is Denied

If a claim for benefits is denied in part or in whole, you may call PayFlex before requesting a formal appeal. PayFlex will try to resolve the issue over the phone; however, if you are not satisfied, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

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

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of service;
- the reason you think your claim should be paid; and
- any documentation or other written information to support your request.

You or your Dependent may send a written request for an appeal to:

PayFlex Systems USA, Inc.
Flex Dept. – Attn: Appeals
P.O. Box 3039
Omaha, NE 68103-3039

Review of an Appeal

PayFlex will conduct a full and fair review of your appeal. The appeal may be reviewed by an appropriate individual(s) who did not make the initial benefit determination. Once the review is complete, if PayFlex upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Appendix G. Applies to Employees participating in the Sandia Day Care Flexible Spending Account

The content in this appendix is applicable to PayFlex Systems USA, Inc. processes. For detailed FSA benefit and plan information, please refer to chapters 1-13 of this Program Summary.

PayFlex Systems USA, Inc. will administer the Day (Dependent) Care Flexible Spending Account for all participating employees.

Claims Filing Process

After you incur an eligible expense, you have the option of submitting a claim online using **Express Claims** or completing a paper claim form and mailing or faxing it along with itemized documentation to PayFlex. Claims may be submitted anytime.

If you have established a Day Care FSA, you can only be reimbursed up to the amount that is available in your account.

Only expenses which are incurred while you are a participant in the Plan or during the Plan year may be reimbursed from a Day Care FSA. An expense is considered incurred when services are provided, not when you are billed or when you pay for care.

Requests for withdrawal will be accepted and processed through April 15 of the following year for expenses incurred during the Plan year.

Options for Reimbursement

Submitting Express Claims online at www.healthhub.com:

Fax in a claim form with the itemized receipts to 402-231-4310.

Mail in a claim form with the itemized receipts to:

PayFlex Systems USA, Inc.
P.O. Box 3039
Omaha, NE 68103-3039

If you have enrolled in e-Notify, you will receive an email once your claim has been processed.

Overpayment Procedures

It is possible, although not common, to have a negative balance in your Day Care FSA account. The transaction information for the PayFlex account is updated daily. If this occurs, you should notify PayFlex at 1-800-284-4885. PayFlex will advise you of the overpayment procedures to begin the *recoupment process.*

Contacting PayFlex

PayFlex Systems USA, Inc.
P.O. Box 3039
Omaha, NE 68103-3039
www.healthhub.com
800-284-4885 (phone)
402-231-4310 (fax)
Monday – Friday, 7:00 a.m. – 7:00 p.m. CT
Saturday, 9:00 a.m. – 2:00 p.m. CT

Claim Denials and Appeals

If Your Claim is Denied

If a claim for benefits is denied in part or in whole, you may call PayFlex before requesting a formal appeal. PayFlex will try to resolve the issue over the phone; however, if you are not satisfied, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

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

- the child's name;
- the provider's name;
- the date of service;
- the reason you think your claim should be paid; and
- any documentation or other written information to support your request.

You or your Dependent may send a written request for an appeal to:

PayFlex Systems USA, Inc.
Flex Dept. – Attn: Appeals
P.O. Box 3039
Omaha, NE 68103-3039

Review of an Appeal

PayFlex will conduct a full and fair review of your appeal. The appeal may be reviewed by an appropriate individual(s) who did not make the initial benefit determination. Once the review is complete, if PayFlex upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.