



Sandia National Laboratories



**KAISER PERMANENTE®**

# **Traditional Plan**

***Health Maintenance  
Organization (HMO)***

***for***

***Non-Medicare Kaiser Members***

- ***Active Employees***
- ***Retirees***
- ***LTD Terminees***
- ***Surviving Spouses***

**Summary Plan Description**

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**Effective: January 1, 2008**

# Kaiser Permanente

The Kaiser Health Plan (KHP), a federally qualified health maintenance organization (HMO), provides health care services to its members using doctors and facilities located within a specific geographic area. KHP is the largest HMO in the country.

This booklet is the Summary Plan Description (SPD) that summarizes operations, benefits, and other provisions of interest. More detailed information is contained in the *Kaiser Permanente Traditional Plan—Evidence of Coverage for Sandia Corporation* and *Kaiser Chiropractic Services Amendments of the Kaiser Foundation Health Plan, Inc.—Evidence of Coverage for Sandia Corporation*. If there is any discrepancy between this SPD and the Kaiser Group Agreement, the language of the Kaiser Health Plan documents shall govern. Copies of these documents are available from your Sandia Corporation Benefits Department.

**The Kaiser Health Plan is maintained at the discretion of Sandia. It is not intended to create a contract of employment and does not change the at-will employment relationship between you and Sandia. The Sandia Board of Directors (or designated representative) reserves the right to suspend, change, modify, discontinue, or terminate the Kaiser Plan at any time without prior notice. If the Kaiser Plan should be terminated or changed, it will not affect your right to any benefits to which you have already become entitled.**

# Contents

<b>Section 1. Eligibility.....</b>	<b>1-1</b>
Service Area.....	1-1
Employees .....	1-2
Retirees.....	1-2
Long-Term Disability Terminees .....	1-3
Other Eligible Persons .....	1-3
Eligible Dependents .....	1-3
Class I Dependents.....	1-4
Qualified Medical Child Support Order.....	1-5
Eligibility Appeal Procedures.....	1-6
<b>Section 2. Enrollment and Disenrollment .....</b>	<b>2-1</b>
Employees (Non-Medicare Primary) .....	2-1
Retirees, Survivors and LTD Terminees (Medicare Primary) .....	2-1
Enrolling Dependents.....	2-2
Enrolling Class I Dependents .....	2-2
To Enroll Non-Medicare Primary Class I Dependents in the Kaiser Plan .....	2-2
Notice to New Enrollees About the Continuity of Care Provision.....	2-3
Disenrolling Dependents .....	2-4
Events Causing Your Dependent to Become Ineligible .....	2-4
How to Disenroll Dependents.....	2-5
Consequence of Not Disenrolling Ineligible Dependents .....	2-5
HIPAA Rights .....	2-6
Waiving or Dropping Coverage in Sandia-Sponsored Medical Plans .....	2-6
How to Waive or Drop Coverage.....	2-7
Coverage During Leaves of Absence .....	2-7
Mid-Year Election Change Events .....	2-8
<b>Section 3. Group Health Plan Premiums.....</b>	<b>3-1</b>
Monthly Premium Payment for Coverage .....	3-2
Employee Premium.....	3-2
Premium for Retiree Medical Plan Option.....	3-3
Dual Sandians.....	3-4
Domestic Partner Premium – Employees Only .....	3-4
Pre-Tax Premium Plan.....	3-5
Leaves of Absence.....	3-5
Premium for Long-Term Disability (LTD) Terminee Medical Plan Option .....	3-6
Premium for Surviving Spouse Medical Plan Option.....	3-6
COBRA Premium .....	3-7
<b>Section 4. Plan Information and Getting Started.....</b>	<b>4-1</b>
How the Plan Works.....	4-1
Your Member ID Card .....	4-2
Member Services .....	4-2

<b>Section 5. When Coverage Stops .....</b>	<b>5-1</b>
Active Employees, Retirees, and Survivors .....	5-1
Class I Dependents.....	5-1
Termination by Kaiser for Cause.....	5-2
Certificate of Group Health Plan Coverage.....	5-2
<b>Section 6. Continuation of Group Health Coverage.....</b>	<b>6-1</b>
Retiree Medical Plan Option .....	6-1
Long-Term Disability Terminatee Medical Plan Option.....	6-2
Surviving Spouse Medical Plan Option .....	6-2
Special Rules .....	6-3
Termination Rules .....	6-3
During Leaves of Absence .....	6-3
COBRA .....	6-4
Qualifying Events Causing Loss of Coverage.....	6-5
Notification of Election of COBRA.....	6-6
Benefits Under Temporary Continuation Coverage.....	6-7
Termination of Temporary Continuation Coverage.....	6-7
Disability Extension and Multiple Qualifying Events .....	6-8

## **APPENDICES**

<b>A. Acronyms and Definitions .....</b>	<b>A-1</b>
<b>B. Health Insurance Portability and Accountability Act of 1996 .....</b>	<b>B-1</b>

# Section 1.

# Eligibility

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

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

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## Service Area

This Plan is available to employees and non-Medicare-primary retirees, other eligible persons, and their dependents who live in the following counties: Alameda, Contra Costa, Marin, Sacramento, San Francisco, San Joaquin, Solano, and Stanislaus. Portions of other northern California counties are also included and are indicated by specific ZIP codes outlined in the Kaiser Group Agreement definitions section available through Health, Benefits, and Employee Services (HBE) (505-844-4237).

When you change your residence to **outside** of the service area, coverage will be terminated on the day of the change of residence or work site or the date of written notification to the Benefits Department, whichever is later, provided that Sandia Benefits is given written notification within 31 calendar days of the change. You may switch to an alternate Sandia Health Plan or drop coverage altogether. If you do not provide written notification to the Sandia Benefits Department within 31 calendar days, you and your covered dependents may not be covered by a Sandia Medical Plan.

If you are enrolled in another plan, and you change your residence to **within** the service area, you may elect to enroll yourself and your covered dependents in the HMO Plan provided that you give written notification to Sandia Benefits within 31 calendar days of the changes in residence or work site. Coverage will be effective on the day you change your residence or the date of written notification to the Benefits Department, whichever is later.

The following groups are eligible to enroll in this Plan:

- Active employees not eligible for primary Medicare coverage
- Employees on a leave of absence and not eligible for primary Medicare coverage

- Retirees not eligible for primary Medicare coverage
- Long-term disability termines not eligible for primary Medicare coverage
- Surviving spouses not eligible for primary Medicare coverage
- A covered member who elects temporary coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA)

## Employees

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

- Regular, full- or part-time employees as classified by Sandia for payroll purposes
- Limited-term exempt or non-exempt employees
- Faculty sabbatical appointees not eligible for other group health care coverage
- Year-round student interns who are enrolled in a post-secondary education program and who are not covered by another medical plan

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

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

### EXCEPTIONS

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

## Retirees

Covered members who retire and are enrolled in this Plan and are not eligible for Medicare primary coverage may continue coverage under this Plan. If you elect to remain enrolled in this Plan, this Plan will continue to be your primary coverage as long as you remain enrolled and until such time you become eligible for Medicare primary coverage. Refer to Section 6, Continuation of Group Health Coverage, for more information.

If you retire and are not eligible for primary Medicare coverage, your coverage will default to the Kaiser Traditional Plan for you and your covered dependents who are not eligible for primary Medicare coverage. Alternate Plan options are available during Sandia's open enrollment period, which is held each fall.

## **Long-Term Disability Terminees**

Covered members who become disabled before retirement, and have been approved for and are receiving long-term disability (LTD) benefits under the Sandia Long-Term Disability Plan or the Sandia Long-Term Disability Plus Plan, and are not eligible to have Medicare as their primary coverage, may continue coverage under this Plan. If you elect to remain enrolled in this Plan, it will continue to be your primary coverage so long as you remain enrolled and until such time that you become eligible for Medicare primary coverage. Refer to Section 6, Continuation of Group Health Coverage, for more information.

If you become a long-term disability terminnee and are not eligible for primary Medicare coverage, your coverage will default to the Kaiser Traditional Plan for you and your covered dependents who are not eligible for primary Medicare coverage. Alternate plan options are available during Sandia's open enrollment period, which is held in the fall every year.

## **Other Eligible Persons**

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

- Employee on certain leaves of absence. An employee on inactive status because he/she is on a Sandia Corporation-approved leave of absence, as evidenced by the written approval required for such leave, who otherwise satisfied the eligibility requirements of this Plan, is a covered employee for purposes of coverage under this Plan. Refer to Section 3, Group Health Plan Premiums, for more information.
- Surviving spouse (who is not eligible for Medicare primary coverage) of a regular Sandia employee or retiree. Refer to Section 6, Continuation of Group Health Coverage, for more information.
- Covered member who elects and pays for temporary coverage (COBRA) and pays the appropriate premium when required. Refer to Section 6, Continuation of Group Health Coverage, for more information.

## **Eligible Dependents**

Eligible Plan dependents are those individuals who are dependents of a primary covered member and any child of a primary covered member who is recognized as an alternate recipient in a QMCSO.

In general, dependents of the primary covered member (e.g., employee, retiree, etc.) who are eligible for Medicare primary coverage are not eligible for coverage under this Plan. See the Kaiser Permanente Senior Advantage Plan Summary Plan Description to find out if your dependent is eligible for Medicare primary coverage.

# IMPORTANT

**As an employer, Sandia is obligated to accurately withhold income and employment taxes. If your Plan dependent does not qualify as a tax dependent under Internal Revenue Code (IRC) Section 152 for purposes of health care coverage for the entire year, you may be subject to imputed income. Refer to Section 3, Group Health Plan Premiums, for more information.**

## Class I Dependents

Your Class I dependents who are eligible for coverage under this Plan include dependents who are not eligible for Medicare primary coverage (unless otherwise noted in Eligible Dependents above) and include your:

- Spouse, not legally separated or divorced from you;

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**NOTE: An annulment also makes the spouse ineligible for coverage.**

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- Unmarried child under age 19 including legally adopted children;
- Unmarried child age 19 and over but under age 24 who is financially dependent on you (financial dependency means that you provide more than 50% of their support for the entire calendar year; refer to Appendix A for the definition of financially dependent persons);
- Unmarried child of any age who:
  - Is permanently and totally disabled and is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months,
  - Lives with you, in an institution, or in a home that you provide,
  - Is financially dependent on you;
- Unmarried child who is recognized as an alternate recipient in a QMCSO;
- Other unmarried dependent persons who meet all of the following requirements (excluding foster children):
  - He or she is under age 24,
  - He or she receives from you or your spouse all of his or her support and maintenance,
  - He or she permanently resides with you (the primary member),
  - You or your spouse is the court-appointed guardian (or was before the person reached age 18) or whose parent is an enrolled dependent under your family coverage.

In addition, if you are an employee and are the primary covered member under this Plan, your Class I dependents eligible for coverage also include your:

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

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

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- Your eligible domestic partner's unmarried child under age 19;
- Your eligible domestic partner's unmarried child age 19 and over, but under age 24, who is financially dependent on you (refer to Appendix A for the definition of financially dependent persons);
- Your eligible domestic partner's unmarried child of any age who, because of a physical or mental impairment:
  - Is permanently and totally disabled and is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months,
  - Lives with you, in an institution, or in a home you provide,
  - Is financially dependent on you;
- Unmarried child of your eligible domestic partner who is recognized as an alternate recipient in a QMCSO;
- Other unmarried dependent persons of your eligible domestic partner who meet all of the following requirements (excluding foster children):
  - He or she is under age 24,
  - He or she receives from you or your spouse all of his or her support and maintenance,
  - He or she permanently resides with you (the primary member),
  - You or your domestic partner is the court-appointed guardian (or was before the person reached age 18) or whose parent is an enrolled dependent under your family coverage.

**IMPORTANT**

**Class II dependents are not eligible to enroll in the Kaiser Plan.**

## Qualified Medical Child Support Order

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

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

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

## Eligibility Appeal Procedures

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

You may appeal any eligibility status determination by writing to the Employee Benefits Committee (EBC), Attention: Benefits Dept., MS 1463. You must appeal to the EBC within 180 days of the date of the letter informing you of the eligibility status determination.

Eligibility for incapacitated dependents is determined by Kaiser Permanente.

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**NOTE: If Kaiser denies your claim or network access due to termination by Kaiser for cause as described in the booklet *Kaiser Permanente Traditional Plan—Evidence of Coverage for Sandia Corporation*, your eligibility appeals must be processed through Kaiser as described under the caption *Dispute Resolution*.**

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# Section 2.

# Enrollment and Disenrollment

This section outlines the enrollment procedures for non-Medicare primary employees, retirees, survivors and long-term disability terminees; enrolling Class I dependents; Kaiser's Continuity of Care provision; disenrolling dependents; and the consequences of not disenrolling dependents in a timely manner. It also provides information on your enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the option to waive or drop coverage. For the events that may allow you to make a mid-year election change, see the *Pre-tax Premium Plan* booklet.

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**NOTE: Eligible members may elect to enroll in this Plan once a year during the open enrollment period Sandia holds each fall. If you enroll in this Plan during open enrollment, coverage will be effective January 1 of the following calendar year.**

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## Employees (Non-Medicare Primary)

New hires will enroll in the Kaiser Traditional Health Plan as follows:

- Complete the HR self-service on-line enrollment process, which is on the Sandia Tech Web.

For mid-year election change event enrollment, contact Sandia HBE at 505-844-4237.

**IMPORTANT** You must enroll yourself and your eligible dependents in this Plan within 31 calendar days of your effective hire date; otherwise you will have to wait until the next open enrollment period to enroll with coverage, effective January 1 of the following year. If you enroll in this Plan within 31 calendar days, coverage will be retroactive to your date of hire.

## Retirees, Survivors and LTD Terminees (Medicare Primary)

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To enroll in the Kaiser Traditional Health Plan (outside the open enrollment period Sandia holds in the fall):

- New Kaiser enrollments require a completed and signed Kaiser Enrollment Form Application/Change Form (agreeing to the terms outlined on the enrollment form). Retain a copy of the form as proof of coverage until you receive your ID card(s).
- Mail the enrollment forms to Sandia National Laboratories, Attn: HBE, MS 1463, P.O. Box 5800, Albuquerque, NM 87185-1463.

Sandia HBE will provide you with applicable enrollment forms to complete your enrollment in this Plan.

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**NOTE: A surviving spouse who remarries is not eligible for this Plan.**

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## Enrolling Dependents

### Enrolling Class I Dependents

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All Class I dependents whom you elect to have covered under this Plan must be enrolled within 31 calendar days of the event qualifying them for coverage, such as when they are newly eligible (e.g., birth, adoption, marriage, becoming an employee).

Employees who want to add a domestic partner or a dependent of your domestic partner to your coverage under your medical plan, please refer to the Domestic Partner packet. You can access this packet on the Benefits home page on the internal web or by contacting Sandia HBE at 505-844-4237.

**IMPORTANT** If you miss the 31-calendar-day period, the next opportunity to enroll your eligible Class I dependents is during the open enrollment period Sandia holds in the fall, with coverage effective January 1 of the following year.

### To Enroll Non-Medicare Primary Class I Dependents in the Kaiser Plan

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1. Complete a Medical Plan Enrollment/Disenrollment Packet.

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**NOTE: Employees should refer to Internal Revenue Service (IRS) Publication 501 or consult your tax advisor for more information on whether your dependent qualifies for "pre-tax" health benefits.**

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2. Obtain a copy of the birth, adoption or marriage certificate.
3. Retain a copy for your files.
4. Mail applicable enrollment forms and proof of birth, adoption or marriage to Sandia HBE.

# IMPORTANT

If you are enrolling an eligible dependent because of marriage or birth, you will be allowed to enroll that dependent within the required 31-calendar-day period (for marriage) or the 90-calendar-day period (for birth). If you are enrolling an adopted child, you must submit the placement agreement and/or adoption papers upon enrollment, and you must enroll the adopted child within 31 calendar days of the placement for adoption and/or adoption. Medical expenses of the child before adoption, including birth mother's prenatal, postnatal, and delivery charges, are not covered.

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**NOTE: Contact Sandia HBE at 505-844-4237 for assistance.**

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The effective date of coverage for your Class I dependents enrolled within 31 calendar days of their qualifying event is as follows:

<b>Dependent Due to</b>	<b>Effective Date of Coverage</b>
Marriage	Later of the date of the event creating eligibility or the date Benefits receives completed paperwork
Legal Guardianship	Later of the date of the event creating eligibility or the date Benefits receives completed paperwork
Birth	Retroactive coverage to date of event
Adoption	Retroactive coverage to date of event
Placement for Adoption	Retroactive coverage to date of event

## Notice to New Enrollees About the Continuity of Care Provision

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Under state law, you may be eligible to enroll in Kaiser but still receive treatment for an acute condition from your current non-Kaiser provider. If it is determined by Kaiser that you are eligible, Kaiser will give you a written referral to obtain care for your current acute condition.

To qualify for this temporary out-of-network coverage, the continuing services must be medically appropriate, you must meet certain criteria, and you must submit your request no later than 30 days from the start of your health plan coverage. Also, all of the following conditions must be true:

- Your health plan coverage is in effect;
- You are receiving services during a current episode of care for an acute condition from a non-Plan provider on the effective date of your health plan coverage;
- When you chose this health plan, you were not offered other coverage that included an out-of-network option that would have covered the services of your current non-Plan provider;
- You did not have the option to continue with your previous health plan or to choose a plan that covers the services of your current non-Plan provider;

- The non-Plan provider agrees in writing to Kaiser's standard contractual terms and conditions, including conditions pertaining to providing credentials, payment, and providing services within Kaiser's service area; and
- The services to be provided to you by the non-Plan provider are medically necessary and would be covered services under the terms of your health plan coverage if provided by a Plan provider.

Kaiser will deny your request if Plan providers determine that continuity of care can be maintained without temporary coverage of non-Plan providers. To request a copy of the coverage policy, please call the Kaiser Member Services Call Center at 800-464-4000.

## Disenrolling Dependents

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

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**NOTE: Contact Sandia HBE at 505-844-4237 for assistance.**

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All ineligible dependents must be disenrolled within 31 calendar days of the event that has made him/her ineligible for coverage under this Plan. Plan coverage ends at the end of the month in which he/she became ineligible.

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

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

## Events Causing Your Dependent to Become Ineligible

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

### Class I:

- Divorce or annulment
- Dissolution of domestic partnership
- Legal separation
- Child, or domestic partner's child, marries
- Child, or domestic partner's child, is no longer financially dependent
- Child, or domestic partner's child, no longer meets the age criteria
- Incapacitated child, or domestic partner's incapacitated child, no longer meets incapacitation criteria

- Child is no longer covered under a QMCSO

## How to Disenroll Dependents

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- Complete the Medical Plan Enrollment/Disenrollment Packet.
- Retain a copy for your files.
- Mail the originals, early enough to meet the 31-calendar-day requirement, to HBE at MS 1463.

**IMPORTANT**

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

Forms are available on Sandia's website under Corporate Forms/Benefits or by calling Sandia HBE at 505-844-4237.

Sandia abides by a federal law referred to as the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 in which temporary continued coverage is provided to dependents who would otherwise lose group coverage due to specified events. Refer to Section 6, Continuation of Group Health Coverage, for more information.

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**NOTE: Contact Sandia HBE at 505-844-4237 for COBRA information.**

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## Consequence of Not Disenrolling Ineligible Dependents

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

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

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

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

- Retroactively terminate dependent coverage, effective the end of the month in which the dependent became ineligible.
- Hold the primary covered member personally liable to refund to Sandia all health care plan claims or monthly premiums rendered during the ineligible period.
- Terminate any rights to temporary, continued health care coverage under COBRA.

Sandia may:

- Refund any applicable premium paid by you during the ineligible period.

## HIPAA Rights

The Health Insurance Portability and Accountability Act (HIPAA) provides rights and protections for participants and beneficiaries in group health plans. Under HIPAA, if you waive or drop coverage for yourself and your covered dependents because of other health insurance coverage, and you and/or your covered dependents involuntarily lose eligibility for that coverage, you may be able to enroll yourself and your eligible dependents during the plan year, provided that you request enrollment and notify Benefits within 31 calendar days of the loss of coverage.

These events include:

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

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

## Waiving or Dropping Coverage in Sandia-Sponsored Medical Plans

You have the option to waive or drop coverage for yourself and your dependents. You can waive coverage when you initially become eligible to enroll in the Plan, or you can elect to drop coverage during the annual open enrollment period Sandia holds each fall. Retirees and survivors can waive or drop coverage at any time during the year.

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

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

## IMPORTANT

**If you are a surviving spouse and you waive or drop coverage, you can never re-enroll in a Sandia-sponsored medical plan.**

### How to Waive or Drop Coverage

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- Complete the Medical Plan Enrollment/Disenrollment Packet.
- Retain a copy for your files.
- Mail the original, early enough to meet the 31-calendar-day criterion to Sandia HBE at MS 1463.

Forms are available on Sandia's website under Corporate Forms/Benefits or by calling the Sandia HBE at 505-844-4237.

## Coverage During Leaves of Absence

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

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

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

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

# IMPORTANT

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

## Mid-Year Election Change Events

Certain events may permit a change to your health care coverage at times other than during open enrollment. Refer to the *Pre-Tax Premium Plan* booklet for more information.

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

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# Section 3.

## Group Health Plan Premiums

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

**IMPORTANT** Benefits paid under a group health plan for your covered dependents who would not qualify as a tax dependent under the IRC for purposes of health care coverage cause the primary covered member to receive additional compensation as taxable wages. The primary covered member is required to declare as taxable income the value of the coverage for the non-eligible dependent. Imputed income is not a pay increase. It is the value of Sandia's contributions for health coverage for dependents who are not your tax dependents. The imputed income will be added to your gross income and may be subject to FICA (Social Security and Medicare) and income taxes. This amount will be reported on your annual W-2 or other appropriate tax form.

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

If you determine that one or more of your covered dependents do not meet the definition of tax dependent as set forth in the IRC for purposes of health care coverage, contact Sandia HBE at 505-844-4237 to obtain a form to complete so that your dependents can be reflected correctly in the database. Refer to the *Pre-Tax Premium Plan* booklet for more information. In addition, in some instances you will have imputed income for those premiums in the calendar year attributable to the dependent before the event that led to his/her ineligibility as a tax dependent, and you need to call Sandia HBE.

**IMPORTANT** It is the responsibility of each primary covered member to determine whether his/her covered dependents meet the plan eligibility requirements of Sandia's plans and the tax dependent rules of the IRC. Should the IRS audit your tax return and determine you have obtained tax benefits for which you are ineligible, you will be responsible for any overdue taxes, interest, and penalties.

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**NOTE: Contact Sandia HBE at 505-844-4237 for assistance in disenrolling your dependents who do not qualify as tax dependents under IRC Section 152 for purposes of health care coverage and/or in determining any taxable income.**

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## Monthly Premium Payment for Coverage

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

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

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

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

Other eligible covered persons pay:

- In a direct payment to Sandia

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**NOTE: Health care premiums, whether taken on a pre- or after-tax basis, are not allowed as reimbursable expenses under the Health Care Reimbursement Spending Account.**

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## Employee Premium

The employee premiums for health care coverage under this Plan are provided during the open enrollment period Sandia holds each fall, from Sandia HBE at 505-844-4237, and online at [www.irm.sandia.gov/hr/benefits/health/premiumindex.htm](http://www.irm.sandia.gov/hr/benefits/health/premiumindex.htm).

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

The premium share is based upon the following family structure:

- Employee only
- Employee and child(ren)
- Employee and spouse
- Employee, spouse, and child(ren)

Sandia currently has three salary tiers for premium share purposes:

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

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

The premium share for the calendar year is based on your base salary as of January 1. If your base salary changes during the year and you are bumped into another tier, your premium share will not change for the remainder of the calendar year. Employees working on a part-time basis (at least 24 hours per week) pay the applicable premium share based on their prorated salary as of January 1; however, part-time employees working fewer than 24 hours per week will pay one-half of the full premium cost (regardless of when they began the work schedule of fewer than 24 hours per week).

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**NOTE: Represented employees should refer to their applicable union agreements for premium-sharing information.**

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

## Premium for Retiree Medical Plan Option

The retiree premiums for continued health care coverage under this Plan are provided during the open enrollment period Sandia holds each fall. Retirees may also contact Sandia HBE at 505-844-4237 for premium rates.

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

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

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

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

Retirees who do not meet any of the above conditions may continue coverage under this Plan by paying the full cost of coverage under COBRA. Refer to Section 6, Continuation of Group Health Coverage, for more information.

## Dual Sandians

If you are a Sandia employee married to another Sandia employee or to a Sandia retiree, you are considered a dual Sandian. As a dual Sandian, you may elect to cover yourself as (1) an individual, (2) a dependent of your Sandia spouse, or (3) as the primary covered employee or retiree, with your Sandia spouse as a dependent. If you, as the employee, are the primary covered member, cost-sharing of monthly contributions will be based on your salary tier. If you and your Sandia spouse elect to be covered separately, any eligible dependents may be covered under either spouse (i.e., some dependents may be enrolled under one spouse while other dependents are enrolled under the other spouse). No dependents may be covered under both Sandians simultaneously.

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

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

## Domestic Partner Premium – Employees Only

Benefits paid under a group health plan for a covered domestic partner, or for covered dependents of a domestic partner, who would not qualify as a tax dependent under the IRC for purposes of health care coverage, cause the employee to receive additional compensation as taxable wages. The employee is required to declare as taxable income the value of the coverage of the domestic partner and his/her dependents as imputed income. Imputed income is not a pay increase. It is the value of Sandia's contributions for health coverage for dependents who are not your tax dependents. The imputed income will be added to your gross income, subject to FICA (Social Security and Medicare) and income taxes, and reported on your annual W-2.

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**NOTE: Premiums for domestic partners and dependents of domestic partners will automatically be deducted on an after-tax basis and imputed income added to your pay UNLESS you contact the Benefits Department and complete an Affidavit of Tax Status to allow them to be designated as tax dependents under IRC Section 152 for purposes of health care coverage.**

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For information on specific premium-sharing provisions for domestic partners, refer to the Domestic Partner packet on the Benefits home page on the internal web or contact Sandia HBE at 505-844-4237 for a copy.

## Pre-Tax Premium Plan

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

Individuals not qualifying as tax dependents under the IRC for purposes of health care coverage must be enrolled individually and cannot be combined as part of the Employee + Spouse, Employee + Children, or Employee + Spouse + Family coverage. Separate monthly premiums must be paid to cover these individuals on an after-tax basis. However, if your dependent becomes ineligible as a tax dependent under the IRC rules for purposes of health care coverage but is still eligible under the health care plans, your pre-tax premiums attributable to that dependent's coverage will be changed to after-tax, as you may not pay any portion of their health plan monthly premiums on a pre-tax basis through the Pre-Tax Premium Plan.

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

## Leaves of Absence

**Child care and family care.** Sandia pays the employer portion of the premiums for continued health care coverage during the first six months of your leave of absence. You will pay the full premium for continued employer group health care coverage beyond the first six months.

If you do not continue your employer group health care coverage during your leave of absence, you will need to re-enroll to reinstate that coverage within 31 calendar days of returning from your leave of absence.

**Tribal government appointees.** Sandia pays the employer portion of the premiums for continued employer group health care coverage during the period of the leave.

If you do not continue your employer group health care coverage during your leave of absence, you will need to re-enroll to reinstate that coverage within 31 calendar days of returning from your leave of absence.

**Military service.** Sandia pays the employer portion of the premiums for continued employer group health care coverage during the first six months of your leave. You will pay the full premium for continued employer group health care coverage beyond the first six months.

If you do not continue your employer group health care coverage during your leave of absence, you will need to re-enroll to reinstate that coverage within 31 calendar days of returning from your leave of absence.

**All other.** Your employer group health care coverage stops at the end of the month in which your leave of absence begins. You are eligible to continue that coverage by paying the full premium, plus a two percent administrative fee, for the duration of your approved leave of absence.

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**NOTE: This coverage runs concurrently with applicable COBRA coverage.**

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If you do not continue your employer group health care coverage during your leave of absence, you will need to re-enroll to reinstate that coverage within 31 calendar days of returning from your leave of absence.

## **Premium for Long-Term Disability (LTD) Terminee Medical Plan Option**

The premiums for continued health care coverage for long-term disability terminees under this Plan are provided during the open enrollment period Sandia holds each fall. LTD terminees may also contact Sandia HBE at 505-844-4237 for premium rates.

- If you became an LTD terminee before January 1, 2003, you pay 10 percent of the full experience-rated premium for you and your covered dependents.
- If you became an LTD terminee after December 31, 2002, you pay 35 percent of the full experience-rated premium for you and your covered dependents.

Refer to Section 6, Continuation of Group Health Coverage, for more information.

## **Premium for Surviving Spouse Medical Plan Option**

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

# IMPORTANT

**If you are a surviving spouse and you waive or drop coverage, you can never re-enroll in a Sandia-sponsored medical plan. A surviving spouse who remarries is no longer eligible for this Plan.**

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

- 50 percent of the full experienced-rated premium if you are a survivor of a retiree or a regular employee with 15 years or more term of employment
- 100 percent of the full experienced-rated premium if you are a survivor of a regular employee with less than 15 years term of employment.

Your decision to continue coverage under the Surviving Spouse Medical Plan Option must be made before the initial six-month coverage expires. The applicable survivor rate will depend on the health care plan under which you are covered and whether coverage is for single or family coverage. Refer to Section 6, Continuation of Group Health Coverage, for more information.

## COBRA Premium

Sandia requires those who elect to continue the employer-provided health coverage to pay the full cost of the coverage, plus a two percent administrative charge. The required COBRA premium is more expensive than the amount active employees pay, but the COBRA premium may be less expensive than individual health coverage. COBRA continuation coverage lasts only for a limited period of time. See Section 6, Continuation of Group Health Coverage, for more information.

As an alternative to electing coverage under the Retiree, LTD Terminee, or Surviving Spouse Medical Plan options, you may choose to continue the active employee health plan coverage by electing COBRA. See Section 6, Continuation of Group Health Coverage, for more information.

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# Section 4.

## Plan Information and Getting Started

This section outlines basic member information you need to get started using the Kaiser Plan.

The *Kaiser Permanente Traditional Plan—Evidence of Coverage for Sandia Corporation* (also found at [http://www.sandia.gov/benefits/spd/pdfs/kasier\\_tradtional\\_plan\\_07.pdf](http://www.sandia.gov/benefits/spd/pdfs/kasier_tradtional_plan_07.pdf)) contains specific information about the following subjects:

- Premiums, Eligibility, and Enrollment
- How to Obtain Services
- Plan Facilities
- Emergency, Post-stabilization, and Out-of-Area Urgent Care from Non-Plan Providers
- Benefits and Cost Sharing
- Exclusions, Limitations, Coordination of Benefits, and Reductions
- Requests for Payment or Services
- Dispute Resolution
- Termination of Membership
- Continuation of Membership

Also see the booklets *Kaiser Permanente Traditional Plan—Evidence of Coverage for Sandia Corporation* and *Chiropractic Services Amendment of the Kaiser Foundation Health Plan, Inc.—Evidence of Coverage for Sandia Corporation* found on the web at [http://www.sandia.gov/benefits/spd/pdfs/kasier\\_tradtional\\_plan\\_07.pdf](http://www.sandia.gov/benefits/spd/pdfs/kasier_tradtional_plan_07.pdf) and [http://www.sandia.gov/benefits/spd/pdfs/kaiser\\_chiropratic.pdf](http://www.sandia.gov/benefits/spd/pdfs/kaiser_chiropratic.pdf).

### How the Plan Works

As a Kaiser member, you are able to choose a primary care physician who is part of a dedicated team of health care specialists, technicians, and nurses. You can also obtain health care advice over the phone 24 hours a day from Kaiser advice nurses. You and your eligible dependents will benefit from one of the largest selections of preventive health care programs and classes available today.

All of the health care services you may need – from routine care with your own primary care physician or specialist to hospitalization, advice nurses, lab and pharmacy services, worldwide emergency benefits, and health education – are provided in the Kaiser Plan.

There are no deductibles and no claim forms to file, and you pay a minimal copayment for most visits. The annual out-of-pocket copay maximum limit is \$1,500 for one person and \$3,000 for two or more people.

## Your Member ID Card

Upon enrollment, Kaiser will assign to you a unique medical record number referenced on your Kaiser member ID card.

Your member (ID) card will give you access to Kaiser services. It will be sent to your home after you enroll.

## Member Services

If you have questions, call Kaiser Member Services at 800-464-4000 to get help in understanding and using your Health Plan benefits. A Member Services representative is available from 7 a.m. to 7 p.m., seven days a week, and will assist you with the following:

- Appointment information,
- Address of the nearest Kaiser location,
- Benefits options upon birth or adoption of a child,
- Obtaining the *Guidebook to Kaiser Permanente Services*,
- Relocation to a new service area when you move to a new address,
- Determining your enrollment or eligibility,
- Checking status or replacing an ID card that is worn or lost, or
- Obtaining a *Travel Guide* information packet.

# Section 5.

## When Coverage Stops

This section outlines when coverage stops for employees, retirees, and Class I dependents, as well as causes for termination by the claims administrator. See Section 6, Continuation of Group Health Coverage, for specific rules governing when health coverage stops and how it may be continued for the above referenced groups.

### Active Employees, Retirees, and Survivors

Plan benefits for active employees and retirees stop on the:

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

**IMPORTANT** Health care coverage may be continued in some situations (refer to Section 6, Continuation of Group Health Coverage, for COBRA rules). Also, special rules apply to leaves of absence for family and medical care (see the Family and Medical Leave Act of 1993 and, for military service, the Uniformed Services Employment and Reemployment Rights Act of 1994).

### Class I Dependents

Plan benefits for dependents stop on the:

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

- Last day of the month in which a dependent child marries or ceases to be eligible under the definition of dependent.
- Last day of the month in which the primary covered member terminates (disenrolls) dependent coverage.

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**NOTE: You must disenroll your dependents within 31 calendar days of the date your dependent becomes ineligible for coverage under this Plan. If you fail to do so, there may be severe consequences. Refer to Section 2, Enrollment and Disenrollment, for more information.**

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Refer to Section 6, Continuation of Group Health Coverage, to determine whether your dependent may be eligible for temporary continued coverage under COBRA and refer to the *Pre-Tax Premium Plan* booklet for specific rules regarding dropping dependent coverage if your medical contribution is taken on a pre-tax basis.

## Termination by Kaiser for Cause

Kaiser may terminate your membership and the membership of your family unit (see definition in Appendix A) immediately upon written notice to you, if certain events occur. These are described in the booklet *Kaiser Permanente Traditional Plan—Evidence of Coverage for Sandia Corporation* under the “Termination of Membership” section, sub-section, “Termination for Cause.”

## Certificate of Group Health Plan Coverage

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

When the Sandia HBE and Kaiser Permanente learn of your loss of medical coverage, or the loss of coverage for your dependents, you will receive a Certificate of Group Health Plan Coverage from Kaiser. This certificate provides proof of your prior health care coverage for the past 18 months or less of coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the six-month period before your enrollment in the new plan. If you become covered under another group health plan, check with the Plan administrator to see if you need to provide this certificate. You may also need this certificate to buy an insurance policy for yourself or your family that does not exclude coverage for medical conditions that are present before you enroll. You also have the right to request (for up to two years following the event that caused the loss of coverage) a Certificate of Group Health Plan Coverage by contacting Sandia’s HBE.

# Section 6.

## Continuation of Group Health Coverage

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

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

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

### Retiree Medical Plan Option

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

Upon retirement, if you are not eligible for Medicare primary coverage, this Plan will be your primary medical coverage until you reach age 65 or you become disabled and are eligible for Medicare primary coverage.

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

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Refer to Section 3, Group Health Plan Premiums, for information on the costs you will pay for coverage as a retiree.

As an alternative to electing coverage under the Retiree Medical Plan Option, the retiree may elect to temporarily continue the same health coverage as available to active employees by making an election under COBRA. Refer to COBRA in this section for more information. If the retiree elects COBRA coverage instead of coverage under the Retiree Medical Plan Option, the retiree cannot elect the Retiree Medical Plan Option after their COBRA coverage has terminated. If the retiree elects the Retiree Medical Plan Option, he/she must waive his/her rights to COBRA as it is an either/or option.

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

If you terminate employment because of a disability and you are approved for and receiving LTD benefits through Sandia, you are eligible to continue health coverage through Sandia until the end of the month in which you recover and the Plan benefit ceases, or you die. You will be allowed to change your medical plan choice every year during the open enrollment period Sandia holds each fall.

If you are under age 65 and have been receiving Social Security disability benefits for 24 months or longer, or if you are age 65 or older, you are eligible for Medicare primary coverage. Medicare will become your primary coverage. Upon becoming eligible for Medicare primary coverage, you must enroll in the Kaiser Permanente Senior Advantage Plan. Refer to Kaiser Permanente Senior Advantage Plan Summary Plan Description, Section 2, Enrollment and Disenrollment, for how to enroll.

Refer to Section 3, Group Health Plan Premiums, for information on the costs you will pay as a disability terminee.

As an alternative to electing coverage under the Long-Term Disability Terminee option, the LTD terminee may elect to temporarily continue the same health coverage as available to active employees by making an election under COBRA. Refer to COBRA in this section for more information. If the LTD terminee elects COBRA coverage instead of the LTD Terminee option, the terminee cannot elect the LTD option after COBRA coverage terminates. If the terminee elects the LTD Terminee option, he/she must waive rights to COBRA, as it is an either/or option.

## **Surviving Spouse Medical Plan Option**

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

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

### EXCEPTION

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

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

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

## Special Rules

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- All Class I dependents covered at the time of death of the employee are eligible for continued health coverage through Sandia.
- No new dependents can be added, except for children born or adopted with respect to a pregnancy or placement for adoption that occurred before the employee's or retiree's death.

## Termination Rules

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For the surviving spouse and dependents, coverage terminates if:

- The spouse marries
- A surviving spouse dies
- Payment is not received when due

Refer to Section 3, Group Health Plan Premiums, for information on the costs you will pay for surviving spouse/dependent coverage.

As an alternative to electing coverage under the Surviving Spouse Option, the surviving spouse and surviving dependents may elect to temporarily continue the same health coverage as available to active employees or non-Medicare primary retirees (whichever is applicable) by making an election under COBRA (refer to COBRA in this section for more information). If the surviving spouse elects COBRA coverage instead of the Surviving Spouse Option, the surviving spouse cannot elect the Surviving Spouse Option after COBRA coverage terminates. If the surviving spouse elects the Surviving Spouse Option, he/she waives his/her rights to COBRA, as it is an either/or option.

## During Leaves of Absence

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

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**NOTE: Refer to CPR 300.6.18, Leaves of Absence, for more detail.**

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

- Child care — to care for a newborn child, a newly adopted child, or a newly placed foster child
- Family care — to care for a seriously ill or injured family member
- Military service — for service in the uniformed services of the United States or with the National Guard
- Tribal government appointments — to accept a tribal government appointment; tribal governor, lieutenant governor, tribal secretary, or tribal treasurer
- Personal — to take care of urgent personal matters
- Personal (educational) – to pursue higher education goals
- Special — to accept assignment with the government, another DOE contractor, or a college or university

Contact Sandia HBE at 505-844-4237 for more information.

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

## COBRA

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

COBRA-qualified beneficiaries may continue health coverage through Sandia by notifying Sandia of a qualifying event (other than termination, reduction of hours, or death of an employee) and by electing COBRA coverage and paying the applicable COBRA rate in a timely manner for health coverage plus a two percent administrative fee. These individuals are referred to as qualified beneficiaries.

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

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## Qualifying Events Causing Loss of Coverage

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

<b>You are the qualified beneficiary if you are the...</b>	<b>and if you, a covered member, lose coverage under this Plan due to...</b>	<b>the maximum period of continuation coverage is...</b>
Employee Spouse Dependent Child	Termination of employee's employment for any reason other than gross misconduct or reduction in employee's hours of employment	18 months
Employee Spouse Dependent Child	Termination of employment (for any reason other than gross misconduct or reduction in employee's hours of employment), and you are disabled or become disabled within the first 60 days of your COBRA coverage, as determined by Social Security, and you do not have Medicare coverage	29 months from the original COBRA qualifying event (after the first 18 months you will be charged 150 percent of the cost of the applicable group rate)
Spouse Dependent Child	Becoming Medicare entitled (applies to covered employee, retiree, or LTD terminnee)  Divorce or legal separation of the spouse from the covered employee, retiree, or LTD terminnee  Death of the covered employee, retiree, or LTD terminnee	36 months
Dependent Child	Loss of dependent child status under the Plan rules	36 months

You may become entitled to an 18-month extension (giving a total maximum period of 36 months of continuation coverage) if you experience a second qualifying event such as the death of an employee, retiree, or LTD terminnee; the divorce or legal separation of the employee, retiree, or LTD terminnee; the covered employee, retiree, or LTD terminnee becoming entitled to Medicare; or a loss of dependent child status under the Plan. The second event can be a second qualifying event only if it would have caused you to lose coverage under the Plan in the absence of the first qualifying event. If a second qualifying event occurs, you will need to notify the Sandia HBE.

## Notification of Election of COBRA

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

Step	Who	Action
1	Employee or family member	<p>Notify Sandia Benefits in writing within 60 days after the date on which the following qualifying event occurs:</p> <ul style="list-style-type: none"> <li>■ Divorce</li> <li>■ Legal separation</li> <li>■ Annulment</li> <li>■ Loss of a child's dependent status</li> <li>■ Disability designation by Social Security</li> </ul> <p>Send notice to: Sandia National Laboratories, Attn: Benefits Department, MS 1463, Albuquerque, NM 87185.</p>
2	Sandia Benefits	Notify Sandia Benefits COBRA administrator of covered member's qualifying event (including termination or reduction of hours of employment, death of employee, etc.).
3	Sandia Benefits COBRA Administrator	Notify qualified beneficiaries of their right to continue health coverage through Sandia and how to make an election. The notice must be provided to the qualified beneficiaries within 14 days after the COBRA Administrator receives the notice of a qualifying event. You may contact the COBRA Administrator by calling Sandia HBE at 505-844-4237.
4	Qualified Beneficiary	<p>Contact the Sandia Benefits COBRA Administrator to elect COBRA coverage.</p> <ul style="list-style-type: none"> <li>■ Qualified beneficiary has 60 days to elect COBRA starting from the later of the date he/she is furnished the COBRA rights notice or the date he/she would lose coverage.</li> <li>■ Qualified beneficiary must make the initial premium payment within 45 days from the COBRA election date. The Plan allows beneficiary a 30-day grace period for monthly premium payment thereafter.</li> <li>■ <b>If beneficiary elects to continue coverage</b>, Sandia provides coverage under the Plan <b>at his/her expense</b> plus the applicable administrative fee.</li> <li>■ <b>If beneficiary does not elect to continue coverage</b> during the 60-day election period, health coverage under Sandia ends at the end of the month in which the event occurred and the qualified beneficiary became ineligible for coverage.</li> </ul>

Step	Who	Action
		<ul style="list-style-type: none"> <li>■ <b>Failure to make any payment</b> within the payment date requirement described above will cause beneficiary to lose all COBRA rights.</li> <li>■ Following the initial payment, if beneficiary does not pay a premium by the first day of a period of coverage, the Plan has the option to cancel his/her coverage until payment is received, and then reinstate the coverage retroactively back to the beginning of the period of coverage. Retroactive reinstatement is not available unless payment is received within 30 calendar days of the due date.</li> <li>■ If the amount of payment is wrong, but is not significantly less than the amount due, the Plan is required to notify beneficiary of the deficiency and grant a period of no longer than 30 days to pay the difference. The Plan is not obligated to send monthly premium notices.</li> </ul>
5	Sandia Benefits COBRA Administrator	Notify qualified beneficiaries of early termination of COBRA continuation coverage if it will end before the maximum period that COBRA coverage is available.

## Benefits Under Temporary Continuation Coverage

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

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

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

## Termination of Temporary Continuation Coverage

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

- Premiums are not paid in full on a timely basis.
- Sandia ceases to maintain any group health plan.
- A qualified beneficiary begins coverage under another group health plan after electing continuation coverage under Sandia, and that plan does not impose an exclusion or limitation affecting a preexisting condition of the qualified beneficiary.

- A qualified beneficiary becomes entitled to Medicare benefits after electing continuation coverage.
- A qualified beneficiary engages in conduct that would justify the Plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud).

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

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

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

- If an individual is disabled (as determined by Social Security) before or during the first 60 days of an 18-month COBRA period, all of the individual's COBRA-eligible family is eligible for an 11-month extension of coverage up to a maximum of 29 months from the original COBRA qualifying event. After the first 18 months of COBRA coverage, the individual will be charged at 150 percent of the cost of the applicable group rate.
- The individual must provide a copy of the Social Security determination within 60 days of the date the disability determination was made and no later than 18 months after the election change event. He/she must also provide notice within 30 days of determination that the qualified beneficiary is no longer disabled.
- In the event of a second election change event (e.g., divorce, employee or retiree dies or becomes covered by Medicare, dependent child loses dependent status) that occurs during the 18-month COBRA coverage period (or during disability extension), the spouse and children already receiving continuation coverage may be eligible for additional months of coverage, up to a maximum of 36 months from the date of the original election change event. The employee must notify Sandia Benefits of the second election change event within 60 days.

# Appendix A

## Acronyms and Definitions

### Acronyms

<b>CMS</b>	Centers for Medicare & Medicaid Services
<b>COB</b>	coordination of benefits
<b>COBRA</b>	Consolidated Omnibus Budget Reconciliation Act
<b>DOC</b>	California Department of Managed Health Care
<b>DMHC</b>	(California) Department of Managed Health Care
<b>EBC</b>	Employee Benefits Committee
<b>ERISA</b>	Employee Retirement Income and Security Act
<b>FICA</b>	Federal Insurance Contributions Act
<b>FMLA</b>	Family and Medical Leave Act
<b>HBE</b>	Sandia Health, Benefits, and Employee Services
<b>HIPAA</b>	Health Insurance Portability and Accountability Act
<b>HMO</b>	health maintenance organization
<b>ID</b>	identification
<b>IMR</b>	Independent Medical Review
<b>IRC</b>	Internal Revenue Code
<b>IRS</b>	Internal Revenue Service
<b>KHP</b>	Kaiser Health Plan
<b>KSAP</b>	Kaiser Senior Advantage Plan

<b>LOA</b>	leave of absence
<b>LTD</b>	long-term disability
<b>PPO</b>	Preferred Provider Organization
<b>PTPP</b>	Pre-Tax Premium Plan (see definition)
<b>QMCSO</b>	Qualified Medical Child Support Order
<b>SPD</b>	Summary Plan Description

# Definitions

## **child**

Under this Plan, a **child** is defined as:

- The primary participant's or domestic partner's own child;
- An adopted child of the primary participant or domestic partner, if the preadoption agreement and/or final adoption papers have been completed and submitted to the Sandia HBE;
- A stepchild who lives with the covered participant at least 50% of the year (stepchildren visiting for the summer are not considered to be living with you) or living in a home provided by you;
- A child of the covered participant, if a court decree requires the covered participant to provide coverage; or
- A child living with the covered participant for whom the covered participant (or covered participant's spouse or eligible domestic partner) is the legal guardian.
- See Eligible Dependents, page 1-3, for an explanation of children to be covered by the Kaiser Plan.

## **claims administrator**

The third party designated by Sandia to receive, process, and pay claims according to the provisions of the Kaiser Plan.

## **Class II Dependent**

Unmarried child, stepchild, grandchild, brother or sister, parent or spouse's parent, step-parent or grandparent. Class II dependents are not eligible to be enrolled under the Kaiser Permanente Traditional or Senior Advantage Health Plans. For more information on the plans that are available to Class II dependents, contact HBE.

**NOTE: A child of a Class I dependent may be eligible under the Kaiser plans (see definition for child).**

## **CMS**

- The Centers for Medicare & Medicaid Services (formerly known as the Health Care Financing Administration) is a federal agency that administers the Medicare program.

## **COBRA**

The federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1987 requires Sandia to offer a temporary extension of health care coverage to primary insureds and dependents who would otherwise lose their group health coverage as a result of certain events (see Qualifying Events Causing Loss of Coverage, page 6-5).

The cost of continued coverage is paid by the insured at the applicable group rate plus a 2% administrative fee.

<b>coordination of benefits (COB)</b>	When a covered member has medical coverage under other group health plans (including Medicare), the Plan benefits are reduced so that the total combined payments from all plans do not exceed 100% of the highest allowed usual and customary (U&C) charges or the lowest negotiated fee.
<b>copayment</b>	Any amount charged to a member at the time of service for covered services.
<b>deductible</b>	The amount you must pay in a calendar year for certain Services before Kaiser will cover those services at the copayment or coinsurance in that calendar year.
<b>dependent</b>	Any eligible member of a subscriber's family who is enrolled and for whom prepayment has been received.
<b>dual Sandians</b>	Both spouses are employed by or retired from Sandia National Laboratories.
<b>family unit</b>	A subscriber and all of his or her enrolled family dependents.
<b>financially dependent persons</b>	Persons who receive more than 50% of their support from the primary subscriber.
<b>Health Care Reimbursement Spending Account</b>	Pre-tax money that is set aside to help pay for health care expenses not reimbursed or only partially reimbursed by any medical, dental, or vision plan or other health insurance plan. This account can be used by active employees only.
<b>hospice</b>	A program provided by a licensed facility or agency that provides home health care, homemaker services, emotional support services, and other services provided to a terminally ill person whose life expectancy is six months or less as certified by the person's physician.
<b>imputed income</b>	The IRS ruled that benefits paid under a group health plan for a dependent who would not qualify as a dependent under state law or as a dependent under the Internal Revenue Code (IRC) causes the employee to receive additional compensation as taxable wages. The employee is required to declare as taxable income the value of the domestic partner's coverage and domestic partner's dependent coverage. Imputed income is not a pay increase. It is the value of Sandia's contributions for health coverage for dependents that are not your tax dependents. The imputed income will be added to your gross income and will be subject to FICA (Social Security and Medicare) and income taxes. This amount will be reported on your annual Form W-2. The definition of a tax dependent is set forth in the IRC. If you have any questions about whether your domestic partner or

dependents are your tax dependents, please consult with the IRS or your tax advisor.

<b>Kaiser Health Plan</b>	The Kaiser Health Plan (KHP) Medical Care Program, composed of Kaiser Foundation Health Plan, Inc. (Health Plan), Kaiser Foundation hospitals, and the Permanente Medical Group, Inc.
<b>Kaiser Permanente Senior Advantage Plan</b>	The Kaiser Permanente Senior Advantage Plan (KPSA) is a Medicare advantage plan (approved by CMS) offered by Kaiser Foundation Health Plan (a Medicare Advantage Organization).
<b>long-term disability terminnee</b>	An employee who has been approved for and is receiving disability benefits under Sandia's Long-Term Disability Plan or Sandia's Long-Term Disability Plus Plan.
<b>Medical Group</b>	The Kaiser Permanente Medical Group, Inc.
<b>Medicare</b>	A medical program administered by the Social Security Administration that provides benefits partially covering the cost of necessary medical care.
<b>Medicare primary</b>	The member is eligible to receive Medicare benefits first before Sandia's plan is required to pay, regardless of whether the member enrolled in Medicare Parts A and B.
<b>member</b>	Any subscriber or enrolled family dependent.
<b>mid-year election change event</b>	An event that allows a primary covered member to make certain changes to their health care coverage. Refer to the <i>Pre-Tax Premium Plan</i> booklet.
<b>nonmember rate</b>	A fee charged when services are provided to nonmembers or to members when they are not covered for that specific service.
<b>open enrollment period</b>	The period of time every year when you may select your medical coverage for the subsequent calendar year.
<b>out-of-pocket maximum</b>	The member's financial responsibility for covered medical expenses for that calendar year.
<b>Peer Review Organization</b>	A group of doctors paid by the federal government to review the medical necessity, appropriateness, and quality of hospital treatment furnished to you and/or to monitor the quality of care provided to Medicare beneficiaries.

<b>physician</b>	<p>Any of the following licensed practitioners who perform a service payable under this Plan:</p> <ul style="list-style-type: none"> <li>■ A doctor of medicine (MD), osteopathy (DO), podiatry (DPM), or chiropractic (DC);</li> <li>■ A licensed doctoral, clinical psychologist;</li> <li>■ A Master's-level counselor and licensed or certified social worker who is acting under the supervision of a doctor of medicine or a licensed doctoral, clinical psychologist;</li> <li>■ A licensed physician's assistant (PA);</li> <li>■ A licensed nurse practitioner; or</li> </ul> <p>Where required to cover by law, any other licensed practitioner who:</p> <ul style="list-style-type: none"> <li>■ is acting within the scope of his/her license and</li> <li>■ performs a service that is payable under this Plan.</li> </ul> <p>A physician eligible for reimbursement by the Plan does not include a person who lives with you or is part of your family (you, your spouse, or a child, brother, sister, or parent of you or your spouse).</p>
<b>Plan administrator</b>	Sandia National Laboratories
<b>Plan documents</b>	<p>Plan documents include the following:</p> <ul style="list-style-type: none"> <li>■ Summary Plan Description (SPD),</li> <li>■ Summary Annual Reports (SARs),</li> <li>■ Administrative Manual,</li> <li>■ Copies of annual reports (5500s) and supporting financial reports and statements (Schedule A), and</li> <li>■ Kaiser Group Agreement.</li> </ul>
<b>post-secondary education program</b>	Junior college, college, or university education programs (they do not apply to high school students).
<b>Pre-Tax Premium Plan</b>	A plan that allows employees to pay for premiums on a pre-tax basis.
<b>primary covered member</b>	The person for whom the coverage is issued, that is, the Sandia employee, retiree, survivor, or the individual who is purchasing coverage.
<b>qualified beneficiary</b>	An employee, spouse, or dependent covered the day before the qualifying event, including a child who is born to or placed for adoption with the covered employee during COBRA. Qualified beneficiaries must be given the same rights as similarly situated employees/beneficiaries.

**Qualified Medical Child Support Order**

A judgment, decree, order, or property settlement agreement issued either by a court of competent jurisdiction or through an administrative process established under state law. The administrative process must have the force and effect of law in that state in connection with state domestic relation law that enforces certain laws relating to medical child support.

**qualifying event**

Under COBRA, an event that but for the COBRA requirements would result in the loss of coverage to a qualified beneficiary.

**service area**

The geographical area designated by Kaiser within the following 15 northern California counties: Alameda, Amador, Contra Costa, El Dorado, Fresno, San Joaquin, San Mateo, Santa Clara, Solano, Sonoma, Sutter, Stanislaus, Tulare, Yolo, and Yuba. Also includes partial counties designated by specific ZIP codes.

**subrogation**

Kaiser's right to recover any Plan costs and payments made because of an illness or injury to you or your covered dependent caused by a third party's wrongful act or negligence and for which you or your covered dependent have a right of action or later recovered payments from the third party.

**subscriber**

A member who is eligible for membership on his or her own behalf through a relationship to group coverage and who meets eligibility requirements.

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# Appendix B. Health Insurance Portability and Accountability Act of 1996

Effective April 14, 2003, a federal law known as the Health Insurance and Portability and Accountability Act of 1996 (HIPAA) required that health plans protect the confidentiality of private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice (see below for further information).

This Plan and Sandia Corporation will not use or further disclose information that is protected by HIPAA ("protected health information") without your written authorization except as necessary for treatment, payment, health plan operations, and plan administration, or as permitted or required by law. By law, the Plan will require all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Sandia National Laboratories.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. Privacy notices are distributed to all new members in the Plan and are distributed to current members under a scheduled time table regulated by HIPAA. In addition, a copy of this notice is available upon request by contacting Kaiser Permanente Member Services. If you have any questions about the privacy of your health information or you wish to file a complaint under HIPAA, contact the HIPAA privacy officer of the Sandia Benefits Department.

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