

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

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

Revised: January 1, 2016

Program Summary

Important

This Program Summary applies to non-represented employees, Pre-Medicare retirees, survivors, and Long Term Disability Terminees effective January 1, 2016.

For more information on other benefit programs, refer to the [Sandia Health Benefits Plan for Employees Summary Plan Description](#) or the [Sandia Health Benefits Plan for Retirees Summary Plan Description](#).

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

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



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Contents

Section 1. Introduction	6
Section 2. Summary of Changes	8
Section 3. Sandia Total Health Plan Design	9
Section 4. How to Obtain Services	22
Sandia Total Health In-Network Services	22
In-Network and Out-of-Network Options	22
Prior Authorization and Referral Requirements for Covered In-Network Services	23
IMPORTANT: Just because a Service or procedure does not require Prior Authorization does not mean that it is a Covered Service	23
Referrals for the Sandia Total Health In-Network Plan level	23
In-Network Self Referrals	23
Prior Authorizations for the Sandia Total Health In-Network Plan option	25
Required Prior-Authorization List for In-Network Benefits	25
Routine Care	25
Urgent Care	25
Advice Nurses	26
Your Personal Physician	26
Second Opinions	26
Telemedicine	26
Your Identification Card	26
Receiving Care in Other Kaiser Permanente Regions	27
Moving outside of the Service Area	27
Getting Assistance for Sandia Total Health (In-Network)	27
Interpreter services for Sandia Total Health (In-Network)	27
In-Network Facilities	27
Health Care Fraud Information	28
Section 5. Deductibles, Out-of-Pocket Maximums, and Lifetime Maximums	29
Deductibles	29
Deductibles for Admissions Spanning Two Calendar Years	31
Coinsurance	31
Out-of-Pocket Maximums	31
Prescription Drug Expenses	34
Lifetime Maximums	34
Travel and Lodging Lifetime Maximum	35
Bone Marrow and Stem Cell Donor Search	35
Section 6. Benefits and Cost Sharing	36
Section 7. Health Reimbursement Account (HRA)	37
Health Reimbursement Account Administrator	37
Health Reimbursement Account (HRA) Amounts	37

Annual Allocation of HRA Contributions.....	37
Events Resulting in Loss of HRA Funds.....	38
New Hires.....	39
Eligible Mid-Year Election Change Events.....	39
Open Enrollment Changes for Dual Sandians	39
What Healthcare Expenses Are Eligible for HRA Reimbursement.....	40
How the HRA Works	40
Example 1:.....	40
Example 2:.....	42
Claims Processing with an HRA.....	42
Medical Expenses	43
Managing your HCFSA/HRA Claim Submissions.....	43
Prescription Drugs.....	43
Health Assessment and Biometric Screenings.....	44
Biometric Screenings Process	44
Health Assessment Process for Employees.....	44
Health Assessment Process for Pre Medicare Retirees, Spouses, Surviving Spouses, and LTD Terminees	44
Virgin Pulse Incentive Management Program.....	45
Tools and Resources to Become a Wiser Consumer	45
Prescription	46
Section 8. Health Care Flexible Spending Account (HCFSA).....	47
Claims Filing Process.....	47
Claims Filing Process with a Health Care FSA and/or HRA.....	47
Special Note regarding Orthodontia Claims Processing.....	48
Options for Reimbursement	48
Kaiser Health Payment Card.....	48
Receiving Your Kaiser Health Payment Card.....	49
Activating Your Kaiser Health Payment Card	49
Using the Kaiser Health Payment Card	49
How does the Kaiser Health Payment Card work?	49
Retailers with Inventory Information Approval System (IIAS)	50
Overpayment Procedures	50
Contacting Kaiser Health Payment Services	50
Claim Denials and Appeals	50
If Your Claim is Denied	50
How to Appeal a Denied Claim	51
Review of an Appeal	51
Section 9. Benefits.....	52
Acupuncture Services.....	52

Auditory Integration Training	53
Allergy Services	53
Ambulance Services	53
(Behavioral) Mental Health and Substance Abuse Services	54
Cancer Services	55
Clinical Trials	55
Chiropractic Services.....	57
Dental Care Covered under In-Network and Out-of-Network Medical	57
Diagnostic Tests	59
Durable Medical Equipment (DME), External Prosthetics and Orthotics DME.....	59
Education and Training for Self-Management	60
Emergency Services	61
Eye/Vision Services	61
Family Planning	62
Genetic Testing	62
Hearing Aids.....	62
Home Health Services.....	63
Home Infusion Services.....	63
Hospice.....	64
Infertility Services	64
Injections in Physician’s Office.....	65
Inpatient Care	66
Maternity Services	66
Medical Supplies	67
Mental Health Services	67
Nutritional Counseling	68
Obesity Surgery – Bariatric Surgery	69
Office Visits - Outpatient Services.....	69
Other Outpatient Services	69
Organ Transplant Services	70
Outpatient Dialysis.....	71
Outpatient Surgical Services	71
Special Oral Foods (Medical Foods)	71
Preventive Care.....	71
Professional Fees for Surgical Procedures	76
Prosthetic Devices/Appliances.....	77
Reconstructive Procedures	77
Rehabilitation and Habilitative Services	78
Skilled Nursing Facility Services	79

Temporomandibular Joint (TMJ) Syndrome	79
Urgent Care Services	80
Section 10. In-Network Services that Require Prior Authorization.....	81
Required Prior-Authorization List for In-Network Benefits	81
Section 11. Prescription Drug Program.....	83
Outpatient Prescription Drugs	83
Covered Preventive Medications	84
Prescriptions Subject to Quantity Limits.....	85
Section 12. Emergency Post-Stabilization, From Non-Network Providers.....	87
Emergency Services	87
Post-Stabilization Care.....	87
Services Not Covered at the In-Network level under this Section	88
Payment and Reimbursement.....	88
Cost Sharing.....	88
Section 13. Definitions	89
Section 14. General Exclusions and General Limitations	95
Section 16. Coordination of Benefits (COB)	104
Section 17. Binding Arbitration	106
Binding Arbitration for Members and Dependents Assigned to the Kaiser Permanente Northern California Region.....	106
Scope of Arbitration.....	106
Initiating Arbitration.....	107
Serving Demand for Arbitration.....	107
Filing Fee.....	108
Number of Arbitrators.....	108
Payment of Arbitrators' Fees and Expenses.....	108
Costs	109
Rules of Procedure.....	109
General Provisions	109
Arbitration Agreement	110
Section 18. Claims and Appeals.....	111
Timing of Claim Determinations	111
Concurrent Care Claims.....	113
Post Service Claims	113
How to File a Claim	114
If a Claim Is Denied.....	115
How to Appeal a Denied Claim	116
Deemed Exhaustion	116
Procedures on Appeal.....	117
Timing of Initial Appeal Determinations.....	118
Notice of Determination on Initial Appeal.....	118

How to File a Final Appeal	119
Timing of Final Appeal Determinations	119
Notice of Determination on Final Appeal.....	119
Next Steps	120
External Review.....	120
Preliminary Review of External Review Request	121
Referral to Independent Review Organization	121
Reversal of Plan’s Decision.....	123
Expedited External Review.....	123
Request for Expedited External Review	124
Preliminary Review	124
Referral to Independent Review Organization	124
Notice of Final External Review Decision.....	124
Your Claim after External Review.....	125
Section 19. Service Areas	126
Service Areas by County & ZIP Code for Northern California	126
Section 20. Customer Service Phone Numbers.....	128

Section 1. Introduction

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

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

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

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

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

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

Language Assistance

SPANISH (Español): Para obtener asistencia en Español, llame al 866-213-3062

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Since these documents will continue to be updated, we recommend that you check back on a regular basis for the most recent version. Sandia reserves the right to amend, reduce, suspend or terminate any of the terms of the plan or coverage with a Notice of Material Modifications to enrollees not later than 60 days prior to the date on which such modification will become effective.

Section 2. Summary of Changes

Benefit changes have been made to your coverage effective 2016. These changes include:

- Adjustments have been made to reflect the in-network HCFSA/HRA claims process to include automatic payment to the providers.
- Clarifications have been made to newborn coverage.

Section 3. Sandia Total Health Plan Design

Effective Date: January 01, 2016

This is a summary of benefits for your Kaiser Permanente deductible exclusive provider network plan with out-of-network benefits.

Overall Plan Features		
Benefit Type	Sandia Total Health In-Network	Sandia Total Health Out of Network
Plan Accumulation Type	Calendar Year	Calendar Year
Annual Plan Deductible		
Per Employee	\$750	\$2,000
Employee + Spouse or Child(ren)	\$1,500	\$4,000
Employee + Spouse and Child(ren)	\$2,250	\$6,000
Each family member has an individual Deductible amount within the family Deductible. The individual cannot contribute to the family Deductible more than the amount of a single Deductible.		
Plan Deductible Accumulates to Out-of-Pocket Maximum	Yes	Yes
Annual Out-of-Pocket Maximum		
Per Employee	\$2,250	\$6,000
Employee + Spouse or Child(ren)	\$4,500	\$12,000
Employee + Spouse and Child(ren)	\$6,750	\$18,000
Each family member has an individual Out-of-Pocket Maximum amount within the family Out-of-Pocket Maximum. The individual cannot contribute to the family Out-of-Pocket Maximum more than the amount of a single Out-of-Pocket Maximum.		
See Outpatient Pharmacy section for separate OOPM.		
ROUTINE PREVENTIVE EXAMS AND SERVICES- See Preventive Exams and Services for a comprehensive list of Preventive Services. Preventive Lab and X-ray screenings not specifically listed within the Preventive Exams and Services section are treated the same as non-preventive Lab and X-ray Services. Frequency and Age Limits managed by Network Provider except where noted. See Preventive Services list at the end of the Benefit Summary.		

Benefit Type	Sandia Total Health In-Network	Sandia Total Health Out of Network	In-Network		Out of Network	
			Applies to Medical Deductible	Applies to Medical OOP	Applies to Medical Deductible	Applies to Medical to OOP
Wellness Exams – Adults (Including Well Woman). Includes vision and hearing screenings. See Vision Exams for Refractions and Hearing Exams for audiologic testing.	\$0	40%	No	N/A	Yes	Yes
Wellness Exams – Children Includes vision and hearing screenings. See Vision Exams for Refractions and Hearing Exams for audiologic testing.	\$0	40%	No	N/A	Yes	Yes
Preventive Screenings	\$0	40%	No	N/A	Yes	Yes
Immunizations (Preventive) Applies to Adults and Children.	\$0	40%	No	N/A	Yes	Yes
OUTPATIENT SERVICES (Office or Outpatient Facility)						
Office Visits						
Primary Care (PCP) Office Visit Cost Share	20%	40%	Yes	Yes	Yes	Yes
Specialty Office Visit Cost Share	20%	40%	Yes	Yes	Yes	Yes
Allergy						
Office Visit Cost Share	20%	40%	Yes	Yes	Yes	Yes
Injection as part of an office visit (Includes serum)	20%	40%	Yes	Yes	Yes	Yes
Injection only (administration and materials)	20%	40%	Yes	Yes	Yes	Yes
Testing	20%	40%	Yes	Yes	Yes	Yes
Biofeedback Services Mental Health Provider	Not covered	Not covered	N/A	N/A	N/A	N/A
Biofeedback Medical Services Provider	Not covered	Not covered	N/A	N/A	N/A	N/A
Cardiac Rehab	20%	40%	Yes	Yes	Yes	Yes

Benefit Type	Sandia Total Health In-Network	Sandia Total Health Out of Network	In-Network		Out of Network	
			Applies to Medical Deductible	Applies to Medical OOP	Applies to Medical Deductible	Applies to Medical to OOP
Chemotherapy Services	20%	40%	Yes	Yes	Yes	Yes
Dialysis Services	20%	40%	Yes	Yes	Yes	Yes
FAMILY PLANNING						
Office Visit Cost Share	20%	40%	Yes	Yes	Yes	Yes
Reversal of Prior Sterilization	20%	40%	Yes	Yes	Yes	Yes
Health Education Office Visit Classes for Self-Management of Asthma, Diabetes, Coronary Disease, Obesity, Overweight and Chronic Pain.	\$0	40%	No	N/A	Yes	Yes
Hearing Exam Audiometry exam	20%	40%	Yes	Yes	Yes	Yes
House Calls (limited by doctor discretion)	20%	40%	Yes	Yes	Yes	Yes
Infusion Services Requires skilled or medical administration.						
Office Visit Cost Share	20%	40%	Yes	Yes	Yes	Yes
Provided during an Office Visit	20%	40%	Yes	Yes	Yes	Yes
Infusion only (cost of administration and materials or Office Visit Cost Share, whichever is less)	20%	40%	Yes	Yes	Yes	Yes
Injections and Immunizations Non-routine						
Office Visit Cost Share	20%	40%	Yes	Yes	Yes	Yes
Provided during an Office Visit	20%	40%	Yes	Yes	Yes	Yes
Injection only (cost of administration and materials or Office Visit Cost Share, whichever is less)	20%	40%	Yes	Yes	Yes	Yes
Travel Immunizations						
Office Visit Cost Share	20%	40%	Yes	Yes	Yes	Yes
Provided during an	20%	40%	Yes	Yes	Yes	Yes

Benefit Type	Sandia Total Health In-Network	Sandia Total Health Out of Network	In-Network		Out of Network	
			Applies to Medical Deductible	Applies to Medical OOP	Applies to Medical Deductible	Applies to Medical to OOP
Office Visit						
Injection only (cost of administration and materials or Office Visit Cost Share, whichever is less)	20%	40%	Yes	Yes	Yes	Yes
Nutritional Counseling	\$0	40%	No	N/A	Yes	Yes
Radiation Therapy	20%	40%	Yes	Yes	Yes	Yes
Respiratory/Pulmonary Therapy	20%	40%	Yes	Yes	Yes	Yes
Vision Refraction Exam						
Office Visit Cost Share-Adult age 19 and greater	\$20	\$30 reimbursement	No	No	No	No
Office Visit Cost Share-Pediatric Age 0-18	\$20	\$30 reimbursement	No	Yes	No	No
Note: Medical care for eye illness or injury is covered under the medical benefit by provider specialty.						
DIAGNOSTIC TESTS & PROCEDURES Preventive Lab and X-ray screenings not specifically listed under the Preventive Screenings section are treated the same as Lab and X-ray Services in this section.						
Diagnostic Lab & X-ray	20%	40%	Yes	Yes	Yes	Yes
High Tech/Advanced Radiology - CT, MRI, Nuclear Medicine and PET	20%	40%	Yes	Yes	Yes	Yes
HOSPITAL/SURGERY SERVICES						
Inpatient Hospital Includes room and board for private and semi-private rooms; ICU/CCU, Acute Rehab, Inpatient Professional Services, Medically Necessary Private Duty Nursing, Ancillary Services, and Supplies. Per Admission.	20%	40%	Yes	Yes	Yes	Yes
AMBULANCE						
Emergency Ground and Air Ambulance	20%	20%	Yes	Yes	Yes	Yes
Scheduled Ground Ambulance	20%	20%	Yes	Yes	Yes	Yes

Benefit Type	Sandia Total Health In-Network	Sandia Total Health Out of Network	In-Network		Out of Network	
			Applies to Medical Deductible	Applies to Medical OOP	Applies to Medical Deductible	Applies to Medical to OOP
Non-Network or Network Hospital to Network Hospital (repatriation)	No charge	No charge	N/A	N/A	N/A	N/A
Emergency Services Accident and Illness.	20%	20%	Yes	Yes	Yes	Yes
Urgent and After Hours Care Urgent Care and After Hours settings	20%	20%	Yes	Yes	Yes	Yes
Outpatient Surgery Performed in Outpatient Hospital or Ambulatory Surgery Center.	20%	40%	Yes	Yes	Yes	Yes
Abortion Elective, Medically Necessary						
Office Visit Cost Share	20%	40%	Yes	Yes	Yes	Yes
Outpatient Surgery	20%	40%	Yes	Yes	Yes	Yes
Inpatient Hospital per admission	20%	40%	Yes	Yes	Yes	Yes
Bariatric Surgery Office Visit Outpatient Surgery Inpatient Hospital per admission	20%	40%	Yes	Yes	Yes	Yes
Temporomandibular Surgery (TMD/TMJ) Office Visit Outpatient Surgery Inpatient Hospital per admission	20%	40%	Yes	Yes	Yes	Yes
Organ Transplants Organ acquisition, diagnostic testing for donor and recipient Office Visit Outpatient Surgery Inpatient Hospital	20%	40%	Yes	Yes	Yes	Yes
Bone Marrow or Stem Cell Donor Search Limits	\$25,000 Benefit Lifetime Maximum					
Travel and Lodging for Organ Transplants For recipient, care-giver and donor						

Benefit Type	Sandia Total Health In-Network	Sandia Total Health Out of Network	In-Network		Out of Network	
			Applies to Medical Deductible	Applies to Medical OOP	Applies to Medical Deductible	Applies to Medical to OOP
Transportation Limits Lodging Limits	\$10,000 per Lifetime shared between Transportation and Lodging	Not covered	N/A	N/A	N/A	N/A
Daily Expense Limits Daily expenses include lodging for up to 2 people or for children, 2 companions up to \$100 max (includes incidental expenses such as meals, excludes personal expenses)	Reimbursement up to \$50 per day per person	Not covered	N/A	N/A	N/A	N/A
MATERNITY						
Routine Pre-Natal and Post-Partum Care						
Visit to confirm pregnancy	20%	40%	Yes	Yes	Yes	Yes
Pre-natal and first post-partum visit	\$0	40%	No	N/A	Yes	Yes
Note: For pregnancy related preventive tests please see preventive list at the end of this benefit summary.						
Hospital Inpatient Includes contracted Birthing Center Per admission	20%	40%	Yes	Yes	Yes	Yes
Home Birth	20%	20%	Yes	Yes	Yes	Yes
INFERTILITY SERVICES						
Services to rule out the underlying medical causes of Infertility are part of the medical benefit. Further diagnosis and treatment of Infertility after initial diagnosis is made will be considered treatment of infertility. Covered treatments include Artificial Insemination, Surgery, Infertility drugs (see Pharmacy section) and GIFT/IVF/ZIFT.						
Hospital Charges Per Admission	20%	40%	Yes	Yes	Yes	Yes
Office Visit Cost Share	20%	40%	Yes	Yes	Yes	Yes
Diagnostic Lab & X-ray	20%	40%	Yes	Yes	Yes	Yes
Outpatient hospital or Ambulatory Surgery Center	20%	40%	Yes	Yes	Yes	Yes
Assisted Reproductive Technology: GIFT, IVF, ZIFT	20%	40%	Yes	Yes	Yes	Yes
Acquisition of Eggs and	20%	20%	Yes	Yes	Yes	Yes

Benefit Type	Sandia Total Health In-Network	Sandia Total Health Out of Network	In-Network		Out of Network	
			Applies to Medical Deductible	Applies to Medical OOP	Applies to Medical Deductible	Applies to Medical to OOP
Sperm						
Embryo Storage and preservation	20%	20%	Yes	Yes	Yes	Yes
Benefit Lifetime Maximum	\$30,000	N/A	N/A	N/A	N/A	
MENTAL HEALTH & CHEMICAL DEPENDENCY SERVICES						
Mental Health - Inpatient (including residential treatment services)	20%	40%	Yes	Yes	Yes	Yes
Partial Hospitalization	20%	40%	Yes	Yes	Yes	Yes
Mental Health - Intensive Outpatient	20%	40%	Yes	Yes	Yes	Yes
Mental Health – Outpatient/Office						
Individual Visit Cost Share	20%	40%	Yes	Yes	Yes	Yes
Group Visit Cost Share	20%	40%	Yes	Yes	Yes	Yes
Chemical Dependency – Inpatient - Detox covered under Medical benefits.(including residential treatment services)	20%	40%	Yes	Yes	Yes	Yes
Chemical Dependency - Partial Hospitalization	20%	40%	Yes	Yes	Yes	Yes
Chemical Dependency - Intensive Outpatient	20%	40%	Yes	Yes	Yes	Yes
Chemical Dependency – Outpatient/Office						
Individual Visit Cost Share	20%	40%	Yes	Yes	Yes	Yes
Group Visit Cost Share	20%	40%	Yes	Yes	Yes	Yes
PHYSICAL, OCCUPATIONAL, & SPEECH THERAPIES						
Physical Therapy	20%	40%	Yes	Yes	Yes	Yes
Visit Maximum	None	None	N/A	N/A	N/A	N/A
Occupational Therapy	20%	40%	Yes	Yes	Yes	Yes
Visit Maximum	None	None	N/A	N/A	N/A	N/A
Speech Therapy	20%	40%	Yes	Yes	Yes	Yes
Visit Maximum	None	None	N/A	N/A	N/A	N/A

Benefit Type	Sandia Total Health In-Network	Sandia Total Health Out of Network	In-Network		Out of Network	
			Applies to Medical Deductible	Applies to Medical OOP	Applies to Medical Deductible	Applies to Medical to OOP
SKILLED CARE						
Home Health Care Nurse visits (2 hours), Aide visits (4 hours), therapy visits and supplies associated with a visit.	20%	40%	Yes	Yes	Yes	Yes
Visit maximum	None	None	N/A	N/A	N/A	N/A
Home Infusion Infusion materials, drugs, and Supplies	20%	40%	Yes	Yes	Yes	Yes
Hospice	20%	40%	Yes	Yes	Yes	Yes
Respite Care for Home Hospice	Up to five consecutive days for each approved admission	Up to five consecutive days for each approved admission	N/A	N/A	N/A	N/A
Skilled Nursing Facility	20%	40%	Yes	Yes	Yes	Yes
Day maximum	None	None	N/A	N/A	N/A	N/A
OTHER SERVICES						
Chiropractic Care (Self Referred Visits)	20%	40%	Yes	Yes	Yes	Yes
Benefit maximum - Only spinal manipulation applies to the Benefit Maximum	\$750 per calendar year	N/A	N/A	N/A	N/A	N/A
Acupuncture (Self Referred Visits)	20%	40%	Yes	Yes	Yes	Yes
Benefit maximum - X- rays do not apply to the Benefit Maximum	\$750 per calendar year	N/A	N/A	N/A	N/A	N/A
Dental Services Services provided by a DDS or DMD not covered under Medical Care. See Summary Plan Description.	20%	40%	Yes	Yes	Yes	Yes
Accidental Injury to Teeth - Repair of sound and natural teeth directly related to an accidental						

Benefit Type	Sandia Total Health In-Network	Sandia Total Health Out of Network	In-Network		Out of Network	
			Applies to Medical Deductible	Applies to Medical OOP	Applies to Medical Deductible	Applies to Medical to OOP
injury. Office Visit Outpatient Surgery Inpatient Hospital per admission *No annual maximum, time limit is 1 year from date treatment begins	20%	40%	Yes	Yes	Yes	Yes
Autism - diagnosis of ASD is required for benefit to apply						
Applied Behavioral Analysis	Not covered	Not covered	N/A	N/A	N/A	N/A
Physical/Occupational/Speech Therapy	See PT/OT/ST					
Durable Medical Equipment (includes Continuous Glucose Monitoring) See Preventive Care List	20%	40%	Yes	Yes	Yes	Yes
Prosthetics and Orthotics - Includes Medically Necessary eyewear for diagnoses of aniridia and aphakia; colostomy/ostomy and urological supplies	20%	40%	Yes	Yes	Yes	Yes
Orthopedic footwear	20%	20%	Yes	Yes	Yes	Yes
Hearing Aids (due to illness or injury) includes test to determine appropriate model, fitting, counseling, adjustment, cleaning and inspection after warranty is exhausted	20%	40%	Yes	Yes	Yes	Yes
Benefit Allowance (per aid per ear)*	Unlimited	Unlimited	Yes	No	Yes	No
Allowance Frequency Limit	every 36 months	every 36 months	N/A	N/A	N/A	N/A
Age limit	Dependent children under the age of 21	Dependent children under	N/A	N/A	N/A	N/A

Benefit Type	Sandia Total Health In-Network	Sandia Total Health Out of Network	In-Network		Out of Network	
			Applies to Medical Deductible	Applies to Medical OOP	Applies to Medical Deductible	Applies to Medical to OOP
		the age of 21				
Special Oral Foods Amino Acid Modified Products	20%	40%	Yes	Yes	Yes	Yes
Optical Hardware Initial pair of contact lenses or glasses when required due to cataract surgery	20%	20%	Yes	Yes	Yes	Yes

Benefit Type	Sandia Total Health In-Network	Sandia Total Health Out of Network	In-Network		Out of Network	
			Applies to Prescription Deductible	Applies to Prescription OOP	Applies to Prescription Deductible	Applies to Prescription OOP
OUTPATIENT PRESCRIPTION DRUGS Obtained from Network Pharmacies and on the KP formulary (list of approved drugs), unless otherwise specified						
Outpatient Prescription Drugs Out of Pocket Maximum						
Per Person	\$1,500	None	N/A	N/A	N/A	N/A
Per Family	\$5,950	None	N/A	N/A	N/A	N/A
Applies to Plan OOPM	No	N/A	N/A	N/A	N/A	N/A
Retail						
Generic	20% \$5 Min/\$10 Max (Min/Max applies p/30 days, p/prescription) Rolls up to 100 Days	50%/ up to 30 Days	No	No	No	No
Formulary Brand	30% \$25 Min/\$40 Max (Min/Max applies p/30 days, p/prescription) Rolls up to 100 Days	50%/up to 30 Days	No	No	No	No
Non-Formulary Brand	40% \$40 Min/\$60 Max (Min/Max applies p/30 days, p/prescription)	50%/ up to 30 Days	No	No	No	No

Benefit Type	Sandia Total Health In-Network	Sandia Total Health Out of Network	In-Network		Out of Network	
			Applies to Prescription Deductible	Applies to Prescription OOP	Applies to Prescription Deductible	Applies to Prescription OOP
	Rolls up to 100 Days					
Preventive Tier	\$0	Not covered	No	N/A	No	No
Mail Order Drugs						
Generic	20% \$12.50 Min/\$25 Max Up to 100 Days' Supply	Not Covered	No	Yes	N/A	N/A
Formulary Brand	30% \$62.50 Min/\$100 Max Up to 100 Days	Not Covered	No	Yes	N/A	N/A
Non-Formulary Brand	40% \$100 Min/\$150 Max Up to 100 Days	Not Covered	No	Yes	N/A	N/A
Preventive Tier Mail Order	\$0	Not covered	No	N/A	N/A	N/A
Blood Factors	\$0	50%/up to 30 Days	No	N/A	No	No
Diabetic Coverage						
Oral medications and insulin	Applicable Formulary Generic/ Brand/ Non-Formulary Cost Sharing	50%/up to 30 Days	No	Yes	No	No
Diabetic testing supplies (meters, test strips)	Applicable Formulary Generic/ Brand/ Non-Formulary Cost Sharing	50%/up to 30 Days	No	Yes	No	No
Diabetic administration devices (syringes)	Applicable Formulary Generic/ Brand/ Non-Formulary Cost Sharing	50%/up to 30 Days	No	Yes	No	No
Infertility Drug Coverage	Applicable Formulary Generic/ Brand/ Non-Formulary Cost Sharing	50%/up to 30 Days	No	Yes	No	No

Benefit Type	Sandia Total Health In-Network	Sandia Total Health Out of Network	In-Network		Out of Network	
			Applies to Prescription Deductible	Applies to Prescription OOP	Applies to Prescription Deductible	Applies to Prescription OOP
Sexual Dysfunction Limit of 8 pills/30 days, 27 pills/100 days	Applicable Formulary Generic/ Brand/ Non-Formulary Cost Sharing	50%/up to 30 Days	No	Yes	No	No
Smoking Cessation (Includes Nicotrol NS Nasal Spray Inhaler Kits 3 kits/30 days, max 360 days per lifetime. See Preventive Medications List at end of Benefit Summary)	\$0 on Preventive List Formulary Brand/Generic/Non-Formulary if not on list	Not covered	No	Yes	No	No
Weight Loss	Applicable Formulary Generic/ Brand/ Non-Formulary Cost Sharing	50%/up to 30 Days	No	Yes	No	No
ACA Mandated Drugs*						
Contraceptive Devices (diaphragms, cervical caps, etc.) and Contraceptive Drugs	Generic=\$0 Brand=\$0 Non-formulary=40%	50%/up to 30 Days	No	No	No	No
Emergency Contraception*	\$0	50%/up to 30 Days	No	N/A	No	No
Anti-Breast Cancer Drug	\$0	50%/up to 30 Days	No	N/A	No	No
OTC*						
Aspirin	\$0	Not covered	No	N/A	N/A	N/A
Oral Fluoride	\$0	Not covered	No	N/A	N/A	N/A

Benefit Type	Sandia Total Health In-Network	Sandia Total Health Out of Network	In-Network		Out of Network	
			Applies to Prescription Deductible	Applies to Prescription OOP	Applies to Prescription Deductible	Applies to Prescription OOP
Folic Acid	\$0	Not covered	No	N/A	N/A	N/A
Iron Supplements	\$0	Not covered	No	N/A	N/A	N/A
Vitamin D	\$0	Not covered	No	N/A	N/A	N/A
Female Contraceptives (spermicides, female condoms, emergency contraceptives and sponges)**	\$0	Not covered	No	N/A	N/A	N/A
Generic bowel cleanser	\$0	Not covered	No	N/A	N/A	N/A
<p>* With prescription, no cost share. Without prescription, Participant pays retail cost **Except for Contraceptive foams, jellies, and ointments which are not covered + Out-of-Network care is subject to retrospective review for medical necessity. You will be responsible for any services determined to be not medically necessary.</p>						
<p>For items or injections dispensed by Pharmacy and requiring skilled administration in the Physician's Office (Implantable contraceptives, administered meds, etc.) Office Visit Cost Share for administration may apply.</p>						
<p>NOTE: Kaiser Permanente's EPO Provider Network will be utilized for in-network Services.</p>						
<p>Sandia will reimburse out-of-network services at the 90th percentile of KPIC default reasonable and customary rates and employees will be financially liable for additional billed amounts.</p>						

Section 4. How to Obtain Services

Sandia Total Health In-Network Services

Network Facilities for your area are listed in greater detail on kp.org, which details the types of Covered Services that are available from each Network Facility in your area because some Network Facilities provide only specific types of Covered Services. It explains how to make appointments, lists hours of operation, and includes a detailed telephone directory for appointments and advice.

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

In-Network and Out-of-Network Options

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

Note: You can use the In-Network or Out-of-Network option at any time during the year, any time you need medical care. Out-of-Network care is subject to retrospective review for medical necessity. You will be responsible for any services determined to be not medically necessary.

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

The advantages of using the In-Network option include:

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

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

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

- Certain Dental Services
- Orthopedic shoes
- Infertility
 - Purchase of Eggs and Sperm
 - Limited donor expenses for egg donor (only the same charges that would be eligible to extract the egg from a covered employee are allowed for the donor; prescription medications taken by a donor are not allowable charges)
 - Storing and preserving embryos for up to two years
- Maternity
 - Birthing services rendered in the home
- Reversal of Prior Sterilizations

If you are admitted to a hospital for an Emergency Medical Condition that is Out of Network and Services are covered, In-Network benefits will be paid until you are stabilized. Once stabilized, you must be moved to a Network Hospital to continue In-Network benefits. You may elect to remain in the Out-of-Network hospital and receive Out-of-Network benefits, as long as your Network Physician determines the treatment to be Medically Necessary.

Prior Authorization and Referral Requirements for Covered In-Network Services

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

Referrals for the Sandia Total Health In-Network Plan level

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

In-Network Self Referrals

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

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

- Obstetrical or gynecological care from a Network Provider who specializes in obstetrics or gynecology
- Chiropractic services

Although a referral or prior authorization is not required to receive care from these In-Network providers, the provider may have to get prior authorization for certain Services.

Additionally some KP regions allow self-referral to certain In-Network specialties:

Northwest Region

- Cancer Counseling
- Occupational Health
- Ophthalmology
- Social Services

Georgia Region

- Dermatology
- Ophthalmology

Colorado Region

- Denver/Boulder Service Area

You may self-refer for consultation (routine office) visits to specialty-care departments within Kaiser Permanente with the exception of the anesthesia clinical pain department, laboratory, and radiology and for specialty procedures such as a CT scan, MRI, colonoscopy or surgery.

- Northern and Southern Colorado Service Areas

You may self-refer for consultation (routine office) visits to Plan Physician specialty-care providers identified as eligible to receive direct referrals in the Provider Directory www.kp.org, click “Locate our services” then “Medical staff directory.” You can obtain a paper copy of the directory by calling Member Services toll-free at 1-888-681-7878 or TTY771.

A self-referral provides coverage for routine visits only. Authorization from Kaiser Permanente is required for: (i) Services in addition to those provided as part of the visit, such as surgery; and (ii) visits to Plan Physician specialty-care providers not eligible to receive direct referrals; and (iii) non-Network Physicians. Medical Group physicians in the Denver/Boulder Service Area will not be eligible for self-referrals. Services other than routine office visits with a Plan Physician specialty-care provider eligible to receive self-referrals will not be covered unless authorized by Kaiser Permanente before Services are rendered.

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

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

The provider to whom you are referred will receive a notice of Authorization by fax. You will receive a written notice of the Authorization in the mail. This notice will tell you the physician’s name, address phone number. It will also tell you the time period for which the referral is valid and the services authorized.

Required Prior-Authorization List for In-Network Benefits

- All inpatient and outpatient facility services (excluding emergencies)
- Office based habilitative/rehabilitation: Occupational; Speech, and Physical therapies.
- All services provided outside a KP facility
- All services provided by non-network providers
- Drugs and Durable Medical Equipment not contained on the KP formulary

Routine Care

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

Urgent Care

You may need Urgent Care if you have an illness or injury that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the Urgent Care or advice nurse telephone number (see the “Customer Service Phone Numbers” section or the Your Welcome Book Book) Note: Urgent Care received from a Non-Network emergency department is covered under the Sandia Total Health Out- of-Network Plan level.

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

Advice Nurses

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

Your Personal Physician

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

Second Opinions

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

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

Telemedicine

Interactive video visits between you and your Personal Network Physician are intended to make it more convenient for you to receive medically appropriate Covered Services. When available, you may receive Covered Services listed under the Benefits and Cost Sharing section via interactive video visits, subject to the “General Limitations, Coordination of Benefits, and Reductions” section. You are not required to use interactive video visits. If you do agree to use interactive video visits, Cost Sharing may apply in certain regions for the services you receive (e.g., Primary Care or Specialist Cost Share) please discuss with your physician if you will be charged for these services.

Your Identification Card

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

replace your Kaiser Permanente ID card, please call customer service at 1-800-663-1771.

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

Receiving Care in Other Kaiser Permanente Regions

You will probably receive most Covered Services in the Service Area of the Kaiser Permanente Region where you live or work. If you are in the Service Area of another Kaiser Permanente Region, you may receive Covered Services from Network Providers in that Region, though Services that require a referral or Prior Authorization may differ among Regions. For information about Network Providers or Covered Services in another Region, please call customer service for that Region at the number listed in the Customer Service Phone Numbers section. For assistance before, during, or after traveling within the United States, you can also contact Kaiser Permanente at 951-268-3900. This travel line can assist in helping to fill eligible prescriptions before you leave home, help you find care in a Kaiser Permanente region, or file a claim for reimbursement when you are back.

Moving outside of the Service Area

If you move to an area not within a Kaiser Permanente Service Area you may be required to change your health plan to one that services your area. Please contact your employer for instruction.

Getting Assistance for Sandia Total Health (In-Network)

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

Interpreter services for Sandia Total Health (In-Network)

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

In-Network Facilities

At most Network Facilities, you can usually receive all the Covered Services you need, including specialty care, pharmacy, and lab work. You are not restricted to a particular

Network Facility, and you are encouraged to use the Network Facility that will be most convenient for you:

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

Health Care Fraud Information

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

- Being wary of offers to waive copays, coinsurance, and Deductibles. These costs are passed on to you eventually.
- Being wary of mobile health testing labs. Ask what your health care insurance will be charged for the tests.
- Reviewing the bills from your providers and the Explanation of Benefits (EOB) form you receive from Kaiser Permanente. Verify that services for all charges were received. If there are any discrepancies, call Kaiser Permanente Customer Service at 800-663-1771.
- Being very cautious about giving information about your health care insurance over the phone.
- If you suspect fraud, contact Kaiser Permanente at 800-663-1771

Section 5. Deductibles, Out-of-Pocket Maximums, and Lifetime Maximums

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

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

Deductibles

This section describes your Deductibles. You must first pay the annual Deductible before the Sandia Total Health Program begins to pay for Covered Services. Your annual deductible begins on January 1. When you meet the full Deductible amount, the Sandia Total Health Program begins to pay for eligible, covered expenses at the applicable Coinsurance amount. Deductibles are not prorated for mid-year enrollments.

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

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

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

	In-Network Deductible	Out-of-Network Deductible
Primary Covered Member Only	\$750	\$2,000
Primary Covered Member + Spouse or + Child(ren)*	\$1,500	\$4,000
Primary Covered Member + Spouse and Child(ren)* [also referred to as a “family”]	\$2,250	\$6,000

* Spouse child(ren) for employees

IMPORTANT: Deductibles between in-network and out-of-network do not cross-apply.

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

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

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

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

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

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

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

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

Deductibles for Admissions Spanning Two Calendar Years

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

Coinsurance

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

Certain preventive care as outlined under Coverage Details is provided at 100% coverage when you receive the services from an in-network provider, or if you receive services out-of-network, coverage is at 60% of the Medicare-Approved Amount, after the Deductible (out-of-network balance billing may apply). For information on Non-Covered services, refer to [Section 13: General Exclusions and General Limitations](#).

IMPORTANT: You are responsible for any amount above the Medicare- Approved Amount if you receive services out-of-network. Some services require Preauthorization, otherwise you will receive reduced benefits or, in certain cases, no benefits. For a complete listing of these services, refer to [Section 4: How to Obtain Services](#).

Out-of-Pocket Maximums

This section describes your Out-of-Pocket Maximums. Your Plan includes both a medical and pharmacy Out-of-Pocket Maximum.

Note: Out-of-pocket maximums are not pro-rated for mid-year enrollments.

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

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

If you are dual Sandians and you switch coverages mid-year due to a mid-year qualifying event, any amounts applied towards out-of-pocket maximums will transfer (e.g. you marry another Sandian and you change your coverage to be enrolled under your spouse,

any amounts applied towards your out-of-pocket maximum, as a Primary Covered Member, will be applied towards your dependent deductible under this Program). It is the employee’s responsibility to obtain all out-of-pocket maximum amounts/EOBs from the former administrator, UHC, and to inform the new administrator, Kaiser Permanente, where you and your dependents stand with your out-of-pocket maximums.

Medical Expenses Incurred through Kaiser (the medical claims administrator)

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

* Spouse child(ren) for employees

IMPORTANT: Deductibles between in-network and out-of-network do not cross-apply. The annual out-of-pocket maximum includes the deductible.

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

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

Example: In a calendar year, an employee family of four meets the In-Network family \$6,750.

Out-of-Pocket Maximum as follows:

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

The In-Network out-of-pocket maximum of \$6,750 for the family has been met. For the remainder of the calendar year, any additional covered medical expenses submitted by this family under the In-Network option will be paid at 100 percent of Eligible Charges (except for prescription drugs). If any member of this family, however, seeks Out-of-Network care, the Out-of-Network Out-of-Pocket Maximums will apply.

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

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

The In-Network Out-of-Pocket Maximum of \$4,500 for the retiree plus spouse has been met. For the remainder of the calendar year, any additional covered medical expenses submitted by under the In-Network option will be paid at 100 percent of Eligible Charges (except for prescription drugs). If the retiree or spouse, however, seeks Out-of-Network care, the Out of -Network Out-of-Pocket Maximums will apply.

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

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

Prescription Drug Expenses

	In-Network Option	Out-of-Network Option
Annual Out-of-Pocket Maximum	\$1,500 per person \$5,950 per family	None None

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

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

Lifetime Maximums

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

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

Travel and Lodging Lifetime Maximum

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

Bone Marrow and Stem Cell Donor Search

An overall maximum benefit of \$25,000 per covered recipient In-Network or Out of Network combined.

Section 6. Benefits and Cost Sharing

The only Services that are covered under this Program are those that this “Benefits and Cost Sharing” section says are covered, subject to exclusions and limitations described in this “Benefits and Cost Sharing” section and to all provisions in the General Exclusions, General Limitations, Coordination of Benefits, and Reductions section. Exclusions and limitations that apply only to a particular benefit are described in this “Benefits and Cost Sharing” section. Exclusions, limitations, coordination of benefits, and reductions that apply to all benefits are described in the [General Exclusions and General Limitations](#), and [Coordination of Benefits \(COB\)](#) sections.

The Services described in this section are covered only if all the following conditions are satisfied:

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

Section 7. Health Reimbursement Account (HRA)

Health Reimbursement Account Administrator

Kaiser Permanente will administer the HRA. All of your Kaiser Permanente services will be available on www.kp.org. Once you log into kp.org, click: My Plan and Coverage, then click: Health Payment Services. Kaiser Health Payment Services customer service can be reached at 1- 877-750-3399.

Health Reimbursement Account (HRA) Amounts

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

- Your coverage and enrollment status (active, PreMedicare/single, family, etc.),
- Whether or not you and your covered spouse have completed a Health Assessment by December 30th of the prior year, and
- Whether or not you and your covered spouse have participated in the Virgin Pulse Program.

Annual Allocation of HRA Contributions

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

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

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

Note: In order to receive HRA funding by February 1 for each calendar year, health assessments must be completed by December 30 of the previous year. However, if you complete the Health Assessment by **November 30** of the previous year, you will receive your HRA funds by January 1.

Pre-Medicare retirees and their pre-Medicare spouses, Pre-Medicare surviving spouses, and pre-Medicare Long term disability termines are required to complete their health assessment through the Kaiser Permanente Website by September 30 in the previous year order to receive funding in the following year.

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

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

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

Events Resulting in Loss of HRA Funds

The maximum balance in an HRA is capped at the amounts shown above. If you have an event which forces you to change coverage, your HRA balance will be adjusted accordingly at the beginning of the next calendar year. Example: You are enrolled as Primary Covered Member + spouse and get divorced. At the time of the divorce you have \$2,500 in your HRA. You may keep the HRA funds through the end of the calendar year, but the HRA balance will be reduced to \$1,500 beginning January 1 of the following calendar year, as that is the maximum balance for Primary Covered Member only coverage. For example, if you incur an out-of-pocket medical expense of \$2000 in December that you file in January, you will only have \$1,500 in your HRA to cover that medical expense.

If you terminate employment, you have up to one year to file claims for expenses incurred while you were covered under Sandia Total Health Administered by Kaiser Permanente. If you do not use your HRA funds and do not elect COBRA coverage, you forfeit any remaining HRA funds. Refer to [Sandia Health Benefits Plan for Employees Summary Plan Description](#) for information on continuing coverage under COBRA.

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

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

New Hires

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

Eligible Mid-Year Election Change Events

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

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

Open Enrollment Changes for Dual Sandians

If you switch Primary Covered Members during Open Enrollment, on January 1, the HRA under the new Primary Covered Member will be funded with incentive funds that were earned in the prior year. Rollover funding from previous years will be credited on or around April 1.

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

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

What Healthcare Expenses Are Eligible for HRA Reimbursement

Your Health Reimbursement Account may only be used for IRS 213 (d) Expenses as defined in this Program Summary. For example, if you receive elective cosmetic surgery that is not eligible under the Sandia Total Health, these claims are not eligible for payment by the HRA.

How the HRA Works

Your HRA dollars can be used to pay for Eligible IRS 213 (d) Expenses, including eligible prescription drugs purchased through a Kaiser Permanente Pharmacy, up to the amount allocated to your HRA. HRA funds are available for use by any Covered Member and are not apportioned on a per person basis. For example, if there is \$750 in available HRA funds and a claim is submitted for one member in the amount of \$1,000, and the member has a \$750 Deductible, the full HRA funds of \$750 will be pulled to cover the Deductible portion of the claim.

Example 1:

Year 1:

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

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

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

Year 2:

You complete a Health Assessment for this year, and you have Primary Covered Member only coverage at the beginning of the year. Sandia allocates \$250 to your HRA. You start the year with a balance of \$350 (\$100 from the previous year plus \$250 from this year). During the course of the year, you incur \$100 in eligible medical services. Your annual in-network Deductible is \$750, and the entire \$100 of health services you received is subject to the Deductible. You may use your HRA to cover the Deductible amount.

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

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

Year 3:

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

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

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

Note: For simplicity, pharmacy expenses were not illustrated in the examples. But prescription medication expenses can also be paid for with the Kaiser Permanente Health Care Payment Debit Card for use at a retail pharmacy or the mail-order pharmacy.

Example 2:

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

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

- The HRA can be used to reimburse the \$250 of your and your spouse’s annual healthcare costs. You had \$600 in costs; the first \$250 of the Deductible is paid by the HRA. This means that you must pay an additional \$350 to meet your annual Deductible

There is no remaining balance to roll over to the next calendar year, but at the beginning of the next calendar year Sandia will again allocate another amount to your HRA, depending if you and your spouse take the health assessment and participate in the Virgin Pulse Incentive Program).

Claims Processing with an HRA

In general, if the covered medical service is rendered at a Kaiser Permanente facility in Northern California, and you have HCFSA/HRA funds available, the amounts owed for qualified medical expenses will be deducted from your account(s) and paid directly to your Kaiser Permanente provider. Any payments exceeding your HCFSA/HRA balance will be the patient responsibility subject to deductible, coinsurance, and out-of-pocket maximums.

For Kaiser Permanente Members, a debit card will be issued for your HRA. This debit card can be used for paying eligible IRS 213 (d) expenses at the point of service.

IMPORTANT: You can use your Kaiser Permanente Health Payment Card at the point of service. Your portion (if any) will be paid first from your HCFSA (if you are enrolled), second from your HRA, and third by you.

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

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

Medical Expenses

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

If you see an In-Network provider, and if the service requires payment, you can use your debit card to pay your portion of the cost sharing for medical services. If you do, Kaiser Permanente will pull your share of the cost of the service from your HCFSA and/or HRA. If you have funds in your HCFSA, it will pay first, and then your HRA will pay once the HCFSA is depleted.

If you see an Out-of-Network provider, and if the service requires payment, you can use your debit card to pay your portion of the cost sharing for medical services. If you have funds in your HCFSA, it will pay first, and then your HRA will pay once the HCFSA is depleted.

Managing your HCFSA/HRA Claim Submissions

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

- HCFSA/HRA debit card;
- Submit a manual claim to Kaiser Health Payment Services for reimbursement.

It is possible you may have unused HCFSA 2015 dollars in your old HCFSA, as well as 2016 dollars in your Kaiser Permanente HCFSA. You have until March 15, to use 2015 HCFSA monies.

If you expect to have unused HCFSA 2015 dollars in your HCFSA and plan to use the grace period for reimbursement for unused funds, you must submit a manual claim to Kaiser Permanente Health Plan Services by March 15, 2016.

Remember: You are responsible for managing your HCFSA and HRA funds.

Prescription Drugs

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

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

Note: www.kp.org is designed to provide you with the necessary information and tools you need to manage your Flexible Spending and Health Reimbursement Accounts. To learn more about your HCFSAs and HRAs log-on to www.kp.org. Once you log into www.kp.org click: **My Plan & Coverage**, then click: **Health Payment Services**. You can keep track of the dollars in your HCFSAs and HRAs by going online to www.kp.org or by calling the toll free number on the back of your Kaiser Health Payment card.

Health Assessment and Biometric Screenings

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

Biometric Screenings Process

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

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

Health Assessment Process for Employees

You will need to go to healthassessment.sandia.gov and register your name.

Health Assessment Process for Pre Medicare Retirees, Spouses, Surviving Spouses, and LTD Terminees

In the year of retirement and any year participating in Sandia Total Health Pre-Medicare coverage, you must complete a new health assessment with Kaiser Permanente by September 30. Log on to kp.org/succeed and click "Start a Total Health Assessment Now" on the middle of the homepage. Contact Customer Service at 1-866-433-9284 with questions.

Virgin Pulse Incentive Management Program

Sandia will reward you for getting and staying healthy. You can earn up to an additional \$250 towards your Health Reimbursement Account for next year through this program. Visit virginhealthmiles.sandia.gov for more details or contact HBE at 505-844-4237.

With Virgin Pulse, employees and their covered spouses may participate in healthy activities and get rewarded - with better health and with points. Participants simply track their activities with a *GoZone pedometer* and through the *LifeZone online tracking system*. Visit virginhealthmiles.sandia.gov for more details.

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

Tools and Resources to Become a Wiser Consumer

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

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

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

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

Prescription

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

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

Section 8. Health Care Flexible Spending Account (HCFSA)

The content in this section is applicable to Kaiser Permanente Health Payment Services process. For detailed HCFSA benefit and plan information, please refer to the Flexible Spending Account Summary Plan Description.

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

Claims Filing Process

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

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

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

Refer to [Section 7: Health Reimbursement Account \(HRA\)](#) for detailed information about the HRA.

In general, if the covered medical service is rendered at a Kaiser Permanente facility in Northern California, and you have HCFSA/HRA funds available, the amounts owed for qualified medical expenses will be deducted from your account(s) and paid directly to your Kaiser Permanente provider. Any payments exceeding your HCFSA/HRA balance will be the patient responsibility subject to deductible, coinsurance, and out-of-pocket maximums.

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

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

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

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

Special Note regarding Orthodontia Claims Processing

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

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

Options for Reimbursement

- Submitting on-line at www.kp.org/healthpayment.
- Fax in a claim form with the itemized receipts to 1-877-535-0821.
- Mail in a claim form with the itemized receipts to:

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

Kaiser Health Payment Card

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

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

Receiving Your Kaiser Health Payment Card

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

Activating Your Kaiser Health Payment Card

New members to the Kaiser HRA will need to activate their debit card upon arrival. Just follow the instructions on the debit card carrier to activate your new card.

Using the Kaiser Health Payment Card

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

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

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

Note: It is important that you keep all itemized documentation for the entire plan year in the event the purchase substantiation information is requested by Kaiser Permanente, in order to comply with IRS regulations.

How does the Kaiser Health Payment Card work?

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

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

year and during the grace period. The grace period was a benefit feature elected by Sandia, which allows an extra 2 ½ month period to utilize your HCFSA dollars.

Retailers with Inventory Information Approval System (IIAS)

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

Overpayment Procedures

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

Contacting Kaiser Health Payment Services

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

7:00 am – 9:00 pm CST, M-F

Claim Denials and Appeals

If Your Claim is Denied

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

How to Appeal a Denied Claim

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

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

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

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

Review of an Appeal

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

Section 9. Benefits

The Sandia Total Health Program provides a wide range of medical care services for you and your family. This section outlines the benefits available under the Sandia Total Health Program. For detailed explanations of what is covered under each benefit, refer to the information in the table. For information on your prescription drug benefits, refer to [Section 10: Prescription Drug Program](#).

The following information provides detailed descriptions of Services.

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

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

If a health service is not listed in this section as a Service, or in [Section 13: General Exclusions and General Limitations](#) as a specific exclusion, it may or may not be covered. Contact Kaiser Permanente's Customer Service at 800-663-1771 for information.

Acupuncture Services

Acupuncture and Acupressure services for pain relief and normalization of physiologic functions are covered. Services include passing long, thin needles through the skin to specific points and application of pressure at acupuncture sites. Acupuncture services are covered as follows:

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

For Acupuncture Services Contact:

California Regions: American Specialty Health Plans of California

<https://www.ashlink.com/ASH/public/applications/providersearch/default.aspx>

800-678-9133

Auditory Integration Training

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

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

Allergy Services

Services related to allergies are covered as follows:

- Office visits
- Allergy testing
- Allergy injections (including serum)
- Allergy injections only (administration and materials)

Ambulance Services

Ambulance services provided by a licensed ambulance service are covered as follows. Note that you are required to contact customer service as soon as reasonably possible.

Ground Ambulance Services

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

Air Ambulance Services

- Air ambulance is covered only when ground transportation is impossible or would put life or health in serious jeopardy

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

The following destinations are covered when medically necessary:

- Home to hospital and return
- Home to skilled nursing facility
- Hospital to skilled nursing facility
- Skilled nursing facility to hospital
- Skilled nursing facility to home
- Home to doctor's office
- Hospital to hospital
- Skilled nursing facility to dialysis center and return

Exclusion: Transportation by car, taxi, bus, gurney van, wheelchair van, minivan, and any other type of transportation (other than a licensed ambulance or psychiatric transport van) is not covered, even if it is the only way to travel to an in-network facility.

(Behavioral) Mental Health and Substance Abuse Services

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

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

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

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

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

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

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

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

Cancer Services

Oncology services are covered as follows:

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

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

Clinical Trials

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

You are eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:

- The referring provider is a Network provider who has made this determination.
- The patient provides medical and scientific information establishing this determination.
- You are accepted into a phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening condition and that meets one of the following requirements:
- The study or investigation is approved or funded (which may include funding through in-kind contributions) by at least one of the following:
 - The National Institutes of Health.
 - The Centers for Disease Control and Prevention.
 - The Agency for Health Care Research and Quality.
 - The Centers for Medicare & Medicaid Services.
 - A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
 - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved through a system of peer review that the HHS Secretary determines meets all of the following requirements:
 - It is comparable to the National Institutes of Health system of peer review of studies and investigations.
 - It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having an investigational new drug application.

Exclusions:

- Non-Approved Clinical Trials
- Investigational items or services.
- Items and services that are provided solely for data collection and analysis and that are not used in the direct clinical management of the patient.
- Services which are clearly inconsistent with widely accepted and established standards of care for the patient's diagnosis.

Chiropractic Services

Chiropractic services are covered as follows:

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

For Chiropractic Services Contact:

California Regions, American Specialty Health Plans of California

<https://www.ashlink.com/ASH/public/applications/providersearch/default.aspx>

800-678-9133.

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

Dental Anesthesia

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

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

Dental Services for Radiation Treatment

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

Other Dental Services

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

Dental Services

(Benefit only available Out-of-Network, paid at the In-Network level)

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

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

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

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

Diagnostic Tests

Medically Necessary diagnostic tests are covered as follows:

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

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

In-network DME must be on Kaiser Permanente's DME, External Prosthetic and Orthotic formulary to be covered. A formulary is a list of DME, external prosthetics and orthotics covered by Kaiser Permanente. Examples of covered items include wheelchairs, hospital beds and oxygen. Medical supplies of an expendable nature, such as oxygen tubing, are covered if they are required for the effective use of the DME. Drugs purchased at the pharmacy for use in DME equipment are covered under the Outpatient Prescription Drugs benefit and not this benefit. In order to have coverage you must meet Kaiser Permanente's criteria for use of any equipment and obtain items from a Network Provider. Coverage is limited to the standard item of equipment that adequately meets your medical needs. Kaiser Permanente will decide whether to rent or purchase the covered equipment for your use. You will have to pay for non-covered equipment. Coverage includes fitting and adjustment. When the item continues to be Medically Necessary, coverage includes repair and replacement of the standard item in cases of loss, irreparable damage, wear or replacement required because of a change in your medical condition. You must return the equipment or pay the fair market price of the equipment when it is no longer covered.

Examples of DME include, but are not limited to:

- Wheelchairs
- Hospital Beds
- Equipment for the treatment of chronic or acute respiratory failure or conditions
- Equipment to administer oxygen
- Orthotic appliances when custom manufactured or custom fitted to you
- Oxygen
- Orthopedic shoes (Out-of-Network only, paid at the In-Network level):

- Up to two pairs of custom-made orthopedic shoes per year when necessary due to illness such as diabetes, post-polio, or other such conditions
- Mastectomy bras
 - Up to two bras per calendar year following a mastectomy
- C-PAP machine
- Bilirubin lights
- Braces that stabilize an injured body part and braces to treat curvature of the spine
- Delivery pumps for tube feedings, including tubing and connectors
- Lenses for aphakic patients (those with no lens in the eye) and soft lenses or sclera shells (white supporting tissue of eyeball)

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

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

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

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

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

Education and Training for Self-Management

Health education and training for self-management is covered when provided by a Network Physician or a qualified Network non physician (example: health educator or dietician) using a standardized curriculum to teach you how to self-manage your disease or condition. Education and training may be provided in group or individual sessions. Sample conditions include:

- Asthma
- Diabetes

- Coronary artery disease
- Obesity
- Overweight
- Chronic Pain

Emergency Services

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

Eye/Vision Services

Eye Exam / Eyeglasses / Contact Lenses

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

Comprehensive Vision Examination

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

If you go In-Network through Kaiser Permanente for a Comprehensive Vision Examination, including refraction, the exam is covered as follows: Covered at a \$20 Copayment, no deductible In-Network. Both adult and pediatric vision exams are covered, and the applicability of the service to the out-of-pocket maximum will vary based on the exam type and whether the service is received In-Network.

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

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

Family Planning

The following types of Services and supplies are covered as described under separate headings in this section.

- Sterilization procedures such as vasectomies and tubal ligations
- Medically Appropriate ultrasounds and laparoscopies
- Family planning devices that are implanted or injected by the physician such as IUDs, Norplant, or Depo-Provera
- Reversals of prior sterilizations available. Performed Out-of-Network only, but covered as in-network and paid at 80% after deductible has been met. See section, In-Network and Out-Of-Network Options for cost sharing information
- Surgical, nonsurgical, or drug-induced pregnancy termination
- Health services and associated expenses for elective and therapeutic abortion. Diaphragms and any other birth control obtained at a pharmacy are eligible for coverage.

Genetic Testing

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

Hearing Aids

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

In-Network

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

Out- of-Network

- Member must satisfy \$2,000 annual deductible, before co-insurance payments begin.
- Once the \$2,000 annual deductible is met, the Plan pays 60% coinsurance and the Member pays 40% coinsurance.

- The Member's annual out of pocket maximum is \$6,000 (includes \$2,000 deductible).

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

Home Health Services

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

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

Home Infusion Services

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

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

Hospice

If a Network Physician diagnoses you with a terminal illness and determines that your life expectancy is six (6) months or less, you may choose home-based hospice care instead of traditional Services that you would otherwise receive for your illness. If you choose hospice care, you are choosing to receive care to reduce or relieve pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. You may continue to receive Covered Services for conditions other than the terminal illness. You may change your decision to receive hospice care at any time.

Hospice care is covered as follows:

- Provided on an inpatient basis
- Provided on an Outpatient basis
- Physical, occupational, speech, or respiratory care for the terminally ill person for purposes of symptom control or to enable you to maintain activities of daily living
- Medical social services
- Durable Medical Equipment and Medical supplies
- Short-term grief counseling and bereavement Services
- Respite care
- Dietary counseling

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

Infertility Services

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

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

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

- Medically Appropriate laparoscopies and ultrasounds

- Artificial insemination
- In Vitro Fertilization
- Gamete intrafallopian transfers (GIFT)
- Zygote intrafallopian transfers (ZIFT)
- Embryo transplantation
- Laparoscopies for egg retrieval
- Infertility
- Purchase of eggs and sperm See the In-Network and Out-Of-Network Options section for cost sharing information.
- Limited donor expenses for egg donor (only the same charges that would be eligible to extract the egg from a covered employee are allowed for the donor; prescription medications taken by a donor are not allowable charges) available Out-of-Network only. See the In-Network and Out-Of-Network Options section for cost sharing information.
- Storing and preserving embryos for up to two years available. See the In-Network and Out-Of-Network Options section for cost sharing information.

Prescription Drugs for Infertility Treatments

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

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

Injections in Physician's Office

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

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

- For out-of-network services, you pay 40 percent of Eligible Expenses, after the Deductible

Inpatient Care

Inpatient Covered Services in a hospital are as follows:

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

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

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

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

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

Maternity Services

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

Maternity services are covered as follows:

- Initial visit to the physician to determine pregnancy status
- Pre-natal and post-natal visits
- Charges related to delivery
- Charges for newborn delivery services, paid as follows:
 - Charges billed for well-baby care are paid under the newborn but at the mother’s level of benefit, subject to her Deductible and Out-of-Pocket Limit (e.g., if mom has met her Out-of-Pocket Limit, well-baby charges

will be reimbursed as if the newborn's Out-of-Pocket Limit was met as well)

- Charges billed for the newborn under any other non-well baby ICD-10 code are paid under the newborn and subject to the newborn's Deductible and Out-of-Pocket Limit

Note: The Sandia Total Health Program will pay for Covered Health Services for the newborn for the first 31 calendar days of life. This is regardless of the newborn's condition or whether you enroll the eligible child within the applicable time frame as referenced in the Sandia Health Benefits Plan for Employees Plan Summary Plan Description or the [Sandia Health Benefits Plan for Retirees Summary Plan Description](#) for continued coverage. This coverage does not apply to third generation dependents. The Sandia Total Health Program will pay for maternity services for you, your covered spouse, and your covered children.

Newborn

Note: Applicable to medical claims only. Pharmacy claims processing always requires active eligibility in the claims system.

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

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

Medical Supplies

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

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

Mental Health Services

Evaluation, crisis intervention, and treatment are covered for mental health conditions.

Inpatient

Inpatient psychiatric care (including residential treatment centers) is covered in a Network Hospital or licensed residential treatment facility. Coverage includes room and board, drugs, Services of Network Physicians, and Services of other Network Providers who are mental health professionals.

Outpatient Therapy

The following outpatient mental health care is covered:

- Partial Hospitalization, sometimes known as day-night treatment programs.
- Intensive outpatient programs.
- Individual and group visits for diagnostic evaluation and psychiatric treatment.
- Other Services:
- Psychological testing.
- Biofeedback and electroconvulsive therapy (ECT).
- Visits for the purpose of monitoring drug therapy.

Nutritional Counseling

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

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

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

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

Obesity Surgery – Bariatric Surgery

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

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

Office Visits - Outpatient Services

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

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

Other Outpatient Services

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

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

Organ Transplant Services

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

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

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

Covered Services Include:

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

Limitations:

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

Outpatient Dialysis

Outpatient dialysis Services related to acute renal failure and end-stage renal disease are covered if you satisfy all medical criteria developed by Medical Group and by the facility providing the dialysis.

After referral to a dialysis facility, equipment, training, and medical supplies required for home dialysis are covered. Home dialysis includes home hemodialysis, intermittent peritoneal dialysis, and home continuous ambulatory peritoneal dialysis.

Outpatient Surgical Services

Outpatient Surgery and related services are covered as follows:

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

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

Special Oral Foods (Medical Foods)

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

Preventive Care

Sandia recommends the following preventive care benefit guidelines and schedules to obtain preventive care services listed below. The Sandia Total Health Program will not

cover all care that is preventive in nature, but will cover certain services under the preventive care benefit.

Preventive services may change according to federal guidelines and your benefits will be updated to include these changes as they are made throughout the Plan year. You will be notified at least sixty (60) days in advance, if any item or service is removed from the list of covered services.

For a complete list of current preventive services required under the Patient Protection Affordable Care Act for which cost share does not apply, please call: the customer service number on the back of your ID card or visit:

www.healthcare.gov/center/regulations/prevention.html.

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

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

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

Kaiser Permanente Participant are eligible for many online programs and classes offered at KP Facilities to help you live healthier. Programs and classes coded as FREE are included in your Plan. Quit Smoking, lose weight, and reduce stress are just a few programs / classes offered. Please check online at kp.org or call your local Kaiser Permanente Facility for availability of FREE programs / classes in your Service Area.

IMPORTANT: In order to receive the preventive care benefit, the service must be submitted with a preventive ICD diagnostic code. If it is submitted with a non-preventive ICD diagnostic code, the service will be reimbursed at the applicable benefit level. Routine annual physical exams will be covered under the preventive benefit, even if billed with a non-preventive IDC-9 diagnostic code, so long as a preventive ICD diagnostic code is also billed. It is solely up to the provider as to whether the service is coded as preventive or diagnostic. Neither Sandia nor the Claims Administrator can direct the provider to bill a service in any particular way. The issue as to how it is billed is between you and your provider.

Medical plans with plan years beginning on or after January 1, 2016 must cover the following preventive Services without a Copayment, Coinsurance, or Deductible, when these Services are delivered by a Network provider.

Preventive Services for adults

Age-appropriate preventive medical examination

Discussion with Primary Care Provider regarding alcohol misuse

Discussion with Primary Care Provider regarding obesity and weight management

Abdominal aortic aneurysm — screening by ultrasonography in men who have ever smoked

Blood pressure screening for all adults

Cholesterol screening for adults at higher risk of cardiovascular disease

Colon cancer screening for adults

Prostate cancer screening in men

Depression screening for adults

Type 2 diabetes screening for adults with high blood pressure

Hepatitis C virus screening for persons at high risk of infection and one-time screening for adults

Discussion with Primary Care Provider regarding aspirin for adults at higher risk of cardiovascular disease

Discussion with Primary Care Provider regarding diet counseling for adults at higher risk for chronic disease

Immunizations for adults (doses, recommended ages, and recommended populations vary):

- Hepatitis A
- Hepatitis B
- Herpes zoster
- Human papillomavirus
- Influenza
- Measles, mumps, rubella,
- Meningococcal
- Pneumococcal
- Tetanus, diphtheria, pertussis
- Varicella
- Screening for all adults at higher risk for sexually transmitted infections and counseling for prevention of sexually transmitting infections, including:
 - Chlamydia

- Gonorrhea
- HIV
- Syphilis

Discussion with Primary Care Provider regarding tobacco cessation

Physical therapy to prevent falls in community-dwelling adults who are at increased risk of falling

Over-the-counter drugs when prescribed by a physician for preventive purposes, including:

- Aspirin to reduce the risk of heart attack

Vitamin D supplements for adults to prevent falls

Lung cancer screening including CT scan of the thorax when ordered for smokers

Screening for hepatitis B virus infection in adults and adolescents at high risk for infection

Preventive Services for women, including pregnant women

Age-appropriate preventive medical examination

Discussion with Primary Care Provider regarding chemoprevention in women at higher risk for breast cancer

Discussion with Primary Care Provider regarding inherited susceptibility to breast and/or ovarian cancer

Mammography screening for breast cancer for women

Cervical cancer screening in women

Osteoporosis screening for women

Discussion with Primary Care Provider regarding tobacco cessation

Chlamydia infection screening for sexually active women (and men) at higher risk

Gonorrhea screening for all women at higher risk

Syphilis screening for all pregnant women and other women at higher risk

Anemia screening for pregnant women

Urinary tract or other infection screening for pregnant women

Hepatitis B screening for pregnant women at their first prenatal visit

Discussion with Primary Care Provider about folic acid supplements for women who may become pregnant

Rh incompatibility screening for pregnant women and follow-up testing for women at higher risk

Routine prenatal care visits

Discussion with Primary Care Provider regarding preconception care

Discussion with Primary Care Provider about interventions to promote and support breastfeeding and comprehensive lactation support and counseling

Provision of breastfeeding equipment

Gestational diabetes screening for pregnant women between 24 and 28 weeks of gestation and for pregnant women identified to be at high risk for diabetes

Discussion with Primary Care Provider about interpersonal and domestic violence

Female sterilizations

Prescribed, FDA-approved, contraceptive devices and contraceptive drugs: discussion with Primary Care Provider about contraceptive methods and contraceptive device removal

Over-the-counter folic acid for women to reduce the risk of birth defects when prescribed by a physician for preventive

For women who have family members with breast, ovarian, tubal, or peritoneal cancer, screening for family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1)

Genetic counseling for women with positive screening results

BRCA genetic testing when clinically indicated after genetic counseling.

Breast Cancer Chemoprevention - Consultation and medications prescribed for risk reduction of primary breast cancer in high-risk women

Preventive Services for children

Application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption

Discussion with Primary Care Provider regarding iron supplements for children who are at risk for anemia

Over-the-counter drugs when prescribed by a physician for preventive purposes:

- Iron supplements for children to reduce the risk of anemia
- Oral fluoride for children to reduce the risk of tooth decay

Immunizations for children (doses, recommended ages, and recommended populations vary):

- Diphtheria, tetanus, pertussis
- Haemophilus influenza Type B
- Hepatitis A
- Hepatitis B
- Human papillomavirus
- Inactivated poliovirus

- Influenza
- Measles, mumps, rubella
- Meningococcal
- Pneumococcal
- Rotavirus
- Varicella

Additional information about preventive services

Preventive and other services provided during the same visit

The following cost-sharing rules apply when a mandated preventive service is provided during an office visit:

- If the preventive service is billed separately from the office visit, then cost sharing may apply to the office visit.

The following cost-sharing rules apply if the preventive service is **not** billed separately from the office visit:

- If the primary purpose of the office visit is the delivery of the preventive service, then no cost sharing may apply to the office visit.
- If the primary purpose of the office visit is **not** the delivery of the preventive service, then cost sharing may apply to the office visit.

Professional Fees for Surgical Procedures

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

This Program will pay the following surgical expenses:

- A surgeon will not be paid as both a co-surgeon and an assistant surgeon.
- Expenses for certified first assistants are allowed.
- Incidental procedures are those services carried out at the same time as a more complex, primary procedure. The incidental procedure may be a part of the primary procedure and require little or very little additional time and resources; therefore, they are usually not covered.
- A surgical procedure that is performed and not considered incidental to the primary procedure will be reimbursed at half of the allowable. For example: When bilateral surgical procedures are performed by one or two surgeons, the Sandia Total Health Program will consider the first procedure at the full allowed amount,

and the second procedure will be considered at half of the allowed amount of the listed surgical unit value.

- Foot surgery – for a single surgical field/incision or two surgical fields/incisions on the same foot, the Program will allow the full amount for the procedure commanding the greatest value; half of the full amount for the second procedure; half of the full amount for the third procedure; and a quarter of the full amount for each subsequent procedure.

Prosthetic Devices/Appliances

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

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

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

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

Reconstructive Procedures

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

Improving or restoring physiological function means that the organ or body part is made to work better. The fact that you may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person’s breathing can be improved or restored. There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the

appearance of a body part. Upper eyelid surgery, for example, is sometimes performed to improve vision, which is considered a Reconstructive Procedure, but in other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure and is not covered.

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

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

Rehabilitation and Habilitative Services

Rehabilitation is a treatment or treatments designed to facilitate the process of recovery from injury, illness, or disease to as normal a condition as possible. Habilitative services are therapeutic services that are provided to children with genetic conditions or conditions present from birth to enhance the child's ability to function. Habilitative services are similar to rehabilitative services that are provided to adults or children who acquire a condition later in life. Rehabilitative services are geared toward reacquiring a skill that has been lost or impaired, while habilitative services are provided to help acquire a skill in the first place, such as walking or talking. Habilitative services include, but are not limited to, physical therapy, occupational therapy and speech therapy for the treatment of a child with a congenital or genetic birth defect.

Rehabilitation and Habilitative services for the following types of therapy are covered:

- Inpatient and Outpatient Multidisciplinary Rehabilitation in an approved organized multidisciplinary program or facility.
- Outpatient Physical, Occupational, and Speech Therapy.
- Outpatient Pulmonary rehabilitation
- Outpatient Cardiac rehabilitation

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

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

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

Skilled Nursing Facility Services

Facility services for an Inpatient stay in a Skilled Nursing Facility or inpatient rehabilitation facility are covered. Skilled inpatient Services and supplies must be Services customarily provided by a Skilled Nursing Facility, and must be above the level of custodial or intermediate care. Benefits include:

- Network Physician and nursing Services.
- Room and board.
- Medical social Services.
- Prescribed drugs.
- Respiratory therapy.
- Physical, occupational, and speech therapy.
- Medical equipment ordinarily furnished by the Skilled Nursing Facility.
- Medical supplies.
- Imaging and laboratory Services ordinarily provided by SNFs.
- Blood, blood products and their administration.

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

Benefits are available when skilled nursing and/or inpatient rehabilitation facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or inpatient rehabilitation facility for treatment of a sickness or injury that would have otherwise required an inpatient stay in a hospital.

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

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

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

Temporomandibular Joint (TMJ) Syndrome

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

Urgent Care Services

The Program will cover Urgent Care as follows:

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

Section 10. In-Network Services that Require Prior Authorization

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

Required Prior-Authorization List for In-Network Benefits

- All inpatient and outpatient facility services (excluding emergencies)
- Office based habilitative / rehabilitation: Occupational; Speech, and Physical therapies.
- All services provided outside a KP facility
- All services provided by non-network providers
- Drugs and Durable Medical Equipment not contained on the KP formulary

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

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

Group will refer you to physician(s) at a transplant center, and the Medical Group will authorize the Services if the transplant center's physician(s) determine that they are Medically Necessary.

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

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

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

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

Section 11. Prescription Drug Program

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

Outpatient Prescription Drugs

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

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

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

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

Note: episodic drugs prescribed for the treatment of sexual dysfunction disorders may be limited by number of doses within a 30-day period.

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

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

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

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

Covered Preventive Medications

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

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

- Tobacco cessation products as follows:
 - Nitrol NS
 - Zyban
 - Chantix
 - Nicotine patches

Prescriptions Subject to Quantity Limits

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

- Glucagon auto-injection (limited to two per year)
- Insulin auto injectors (limited to two per year)
- Lovenox (limited to seven days/14 injections)
- Nicotrol Nasal Spray (four inhaler kits per 30 days with a maximum of 360 days per lifetime)
- Sexual dysfunction drugs (e.g., Viagra) are limited to males only and eight pills/30 days at retail or 27 pills/100 days at mail
- Sleep aids (e.g., Ambien) are limited to 15 pills/30 days at retail or 45 pills/90 days at mail
- Relenza diskhaler (one per year)
- Tamiflu (ten capsules per year)

Kaiser Permanente Mail-Order Program (For maintenance prescription drugs)	Kaiser Network Retail Pharmacies	Out-of-Network Retail Pharmacies
Coinsurance of 20% of mail order price with a \$12.50 minimum and \$25 maximum for generic prescription drugs	Coinsurance of 20% of retail discount price with a \$5 minimum and \$10 maximum for generic prescription drugs	50% reimbursement
Coinsurance of 30% of mail order price with a \$62.50 minimum and \$100 maximum for preferred brand name prescription drugs	Coinsurance of 30% of retail discount price with a \$25 minimum and \$40 maximum for preferred brand name prescription drugs	50% reimbursement
Coinsurance of 40% of mail order price with a \$100 and \$150 maximum for non-preferred brand name prescription drugs	Coinsurance of 40% of retail discount price with a \$40 minimum and \$60 maximum for non-preferred brand name prescription drugs	50% reimbursement
No charge for mail order preventive tier prescription drugs	No charge for preventive tier prescription drugs from a retail pharmacy	Retail cost share
Maximum of 100-day supply	Maximum of 30-day supply	Maximum of 30-day supply
Out-of-Pocket Maximum is \$1,500 per person per year and \$5,950 family. Refer to Section 5: Deductibles, Out-of-Pocket Maximums, and Lifetime Maximums for more information.		Out-of-Pocket Maximum does not apply
Coinsurance does not apply to the Sandia Total Health Program medical deductible or out-of-pocket maximum. Reimbursement for prescriptions purchased outside the United States will be reimbursed at the applicable retail Coinsurance, limited to a maximum of a 30-day supply.		

Section 12. Emergency Post-Stabilization, From Non-Network Providers

This section explains how to obtain covered emergency and post-stabilization from non-Network Providers.

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

Emergency Services

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

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

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

Post-Stabilization Care

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

To request Prior Authorization to receive Post-Stabilization Care from a Non-Network Provider, you (or someone on your behalf) must call Kaiser Permanente toll free at the telephone number on your Kaiser Permanente ID card before you receive the care if it is reasonably possible to do so (otherwise, call as soon as reasonably possible). A Kaiser Permanente representative will then discuss your condition with the Non-Network Provider. To be covered at the In-Network level, if Kaiser Permanente decides that you

require Post-Stabilization Care and that this care would be covered if you received it from a Network Provider, they will authorize your care from the Non–Network Provider or arrange to have a Network Provider (or other designated provider) provide the care. If Kaiser Permanente decides to have a Network Hospital, Network Skilled Nursing Facility, or designated Non–Network Provider provide your care, they may authorize special transportation services that are medically required to get you to the provider. If this occurs, then those special transportation services will be covered, even if they would not be covered at the In-Network rate under Ambulance Services in the Benefits and Cost Sharing section if a Network Provider had provided them.

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

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

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

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

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

Payment and Reimbursement

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

Cost Sharing

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

Section 13. Definitions

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

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

Term	Definition
Allowance	A dollar amount the Program will pay for benefits for a service during a specified period of time. Amounts in excess of the Allowance, are your responsibility to pay and do not apply toward your Out-of-Pocket Maximum.
Claims Administrator	KPIC is the self-funded claims administrator. You can find the Claims Administrator’s address in the “Customer Service Phone Numbers” section and on your Kaiser Permanente ID card.
Clinically Stable	You are considered Clinically Stable when your treating physician believes, within a reasonable medical probability and in accord with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during, or as a result of, the discharge or transfer.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985.
Coinsurance	The percentage of a Service which the Program Permanente pays after you have met the Deductible.
Copayment	A specified dollar amount that you must pay for certain Covered Services. If you have outstanding receipts for healthcare expenses incurred in 2012, all requests for reimbursement will be accepted and processed through April 15. After April 15, funds remaining in your 2012 Health Care Flexible Spending Account will be forfeited.
Cost Sharing	Copayments, Coinsurance and Deductibles.
Covered Service	Services that meet the requirements for coverage described in this Program Summary.
Deductible	Eligible Charges incurred during a calendar year that you must pay in full before the Sandia Total Health Program pays benefits. Does not apply to outpatient prescription drugs purchased through Kaiser Permanente.
Dental Services	Items and Services provided in connection with the care, treatment, filling or removal, or replacement of teeth or structures directly supporting the teeth. (Structures supporting the teeth mean the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth and alveolar process.)
Dependent	A person who is enrolled in the Program if the person’s relationship to the Member is the basis for eligibility. This Summary sometimes refers to a Dependent or Member as “you.”

Term	Definition
Durable Medical Equipment (DME)	<p>Durable Medical Equipment (DME) is a device or instrument of a durable nature that meets all of the following requirements:</p> <ul style="list-style-type: none"> • It can withstand repeated use; • It is primarily and customarily used to serve a medical purpose; • It is generally not useful to a person in the absence of illness or injury; and • It is appropriate for use in your home.
Eligible Charges	<ul style="list-style-type: none"> • For Services provided by Kaiser Permanente, the charge in the relevant Kaiser Foundation Health Plan's schedule of Kaiser Permanente charges for Services provided to participants • For Services that Network Providers (other than Kaiser Permanente) provide under a contract with Kaiser Permanente, the amount that the provider has agreed to accept as payment in full under that contract • For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge you for the item if your benefits did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs and other items, the direct and indirect costs of providing Kaiser Permanente pharmacy Services, and the pharmacy program's contribution to the net revenue requirements of the relevant Kaiser Foundation Health Plan) • For all other Services, the amounts that the Plan pays for the Services or, if the Plan subtracts Cost Sharing from its payment, the amount the Plan would have paid if it did not subtract Cost Sharing
Emergency Services	<p>All of the following with respect to an Emergency Medical Condition:</p> <ul style="list-style-type: none"> • A medical screening examination (as required under the Emergency Medical Treatment and Active Labor Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition • Within the capabilities of the staff and facilities available at the hospital, the further medical examination and treatment that the Emergency Medical Treatment and Active Labor Act requires to Stabilize the patient
Emergency Medical Condition	<p>A medical or psychiatric condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:</p> <ul style="list-style-type: none"> • Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy • Serious impairment to bodily functions • Serious dysfunction of any bodily organ or part
ERISA	The Employee Retirement Income Security Act of 1974, as amended.
Family	A Member and all of his or her Dependents.
HIPAA	The Health Insurance Portability and Accountability Act, as amended.

Term	Definition
Hospice	A specialized form of interdisciplinary health care designed to provide palliative care and to alleviate the physical, emotional, and spiritual discomforts you may experience during the last phases of life due to a terminal illness. It also provides support to your primary caregiver and your family.
Kaiser Permanente	A Network of Providers that operate through Regions, each of which has a Service Area. For each Kaiser Permanente Region, Kaiser Permanente consists of Kaiser Foundation Hospitals (a California nonprofit corporation) and the Medical Group for that Region: <ul style="list-style-type: none"> • Kaiser Foundation Health Plan, Inc., for the Northern California Region the Southern California Region, and the Hawaii Region • Kaiser Foundation Health Plan of Colorado for the Colorado Region • Kaiser Foundation Health Plan of Georgia, Inc., for the Georgia Region • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., for the Mid-Atlantic States Region • Kaiser Foundation Health Plan of the Northwest for the Northwest Region
KPIC	Kaiser Permanente Insurance Company, which provides claims administrative services.
Material Modification	Per section 102 of the Employee Retirement Income Security Act of 1974 (ERISA), a material modification includes: <ul style="list-style-type: none"> • Any coverage modification that alone or combined with other changes made at the same time would be considered by “an average participant” to be “an important change in covered benefits or other terms of coverage under the plan or policy.” • An enhancement of covered benefits, services or other more general, plan or policy terms. For example, coverage of previously excluded benefits or reduced cost-sharing. • A “material reduction in covered services or benefits” or more strict requirements for “receipt of benefits,” including: <ul style="list-style-type: none"> ○ Changes or modifications that reduce or eliminate benefits ○ Increases in cost-sharing ○ Imposing a new referral requirement
Medically Necessary	A Service is Medically Necessary if, in the judgment of the Program, it meets all of the following requirements: <ul style="list-style-type: none"> • It is required for the prevention, diagnosis, or treatment of your medical condition • Omission of the Service would adversely affect your condition • It is provided in the least costly medically appropriate setting • It is in accord with generally accepted professional standards of practice that is consistent with a standard of care in the medical community.
Medicare	A federal health insurance program for people age 65 and older, certain people with disabilities or end-stage renal disease (ESRD).

Term	Definition
Member	A person who is enrolled in the Program if that person is eligible in his own right and not because of his or her relationship to someone else. This Summary sometimes refers to a Dependent or Member as “you.”
Network Provider	<p>A Network Hospital, Physician, Pharmacy, Skilled Nursing Facility, Medical Group, or any other health care provider under contract with Kaiser Permanente to provide Covered Services. Network Providers are subject to change at any time without notice. For current locations of Network facilities please call Customer Service at the number listed in the “Customer Service Phone Numbers” section. To find a Kaiser Pharmacy visit www.kp.org - select the Locate Our Services tab, select your region, and then select the Facilities tab.</p> <p>Network Facility</p> <p>Any facility listed in Your Welcome Book or on www.kp.org. Note: Facilities are subject to change at any time, for the current locations, call Customer Service.</p> <p>Network Hospital</p> <p>A licensed hospital owned and operated by Kaiser Foundation Hospitals or another hospital which contracts with Kaiser Foundation Hospitals to provide Covered Services.</p> <p>Network Pharmacy</p> <p>A pharmacy owned and operated by Kaiser Permanente, or another pharmacy that Kaiser Permanente designates.</p> <p>Network Physician</p> <p>A licensed physician who is a partner, shareholder, or employee of the Medical Group, or another licensed physician who contracts with the Medical Group to provide Covered Services.</p> <ul style="list-style-type: none"> • Medical Group: The following medical group is available for Northern California members: <ul style="list-style-type: none"> ◦ The Permanente Medical Group for the Northern California Region • The Southern California Permanente Medical Group for the Southern California Region • Colorado Permanente Medical Group, P.C., for the Colorado Region • The Southeast Permanente Medical Group, Inc., for the Georgia Region • Hawaii Permanente Medical Group, Inc., for the Hawaii Region • Mid-Atlantic Permanente Medical Group, P.C., for the Mid-Atlantic States Region • Northwest Permanente, P.C., Physicians & Surgeons, for the Northwest Region <p>Network Skilled Nursing Facility</p> <p>A licensed facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services that contracts with Kaiser Permanente to provide Covered Services. The facility’s primary business is the provision of 24-hour-a-day skilled nursing care. The term “Skilled Nursing Facility” does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A “Skilled</p>

Term	Definition
Network Provider, cont.	Nursing Facility” may also be a unit or section within another facility as long as it continues to meet the definition.
Non-Network Provider or Out-of-Network Provider	Any licensed provider that is not a Network Provider who provides Covered Services.
Out-of-Pocket Maximum	Your financial responsibility for covered medical expenses before the Program reimburses additional Eligible Charges at 100%, with no Deductible, for the remaining portion of that calendar year.
Plan Administrator	Sandia National Laboratories
Plan Sponsor	The plan sponsor named in the Sandia Total Health Plan Document
Post-Stabilization Care	Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that your condition is Clinically Stable.
Primary Care	Care provided by a Network Provider who specializes in internal medicine, pediatrics or family practice Services.
Prior Authorization	Medical Necessity approval obtained in advance which is required for certain services to be Covered Services under the Program. Authorization is not a guarantee of payment and will not result in payment for services that do not meet the conditions for payment by the Program.
Program	Part of the plan named in the Sandia Total Health Plan Document
Prosthetics and Orthotics	An external prosthetic device is a device that is located outside of the body which replaces all or a portion of a body part or that replaces all or portion of the function of a permanently inoperative or malfunctioning body part. Internally implanted prosthetic devices are devices placed inside the body through a surgical incision which replaces all or a portion of a body part or that replaces all or portion of the function of a permanently inoperative or malfunctioning body part Orthotics are rigid or semi-rigid external devices that are used for the purpose of supporting a weak or deformed body part, improving the function of moveable parts or for restricting or eliminating motion in a diseased or injured part of the body.
Reconstructive Surgery	Surgery is to improve function and under certain conditions, to restore normal appearance after significant disfigurement.
Region	A geographic area serviced by Kaiser Permanente. See “Kaiser Permanente” in this “Definitions” section.
Services	Healthcare, including mental health care, services and items.
Service Area	A smaller geographic area of a Kaiser Permanente Region.
Specialty Care	Care provided by a Network Provider or Non-Network Provider who provides Services other than Primary Care Services.
Stabilize	To provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), “Stabilize”

Term	Definition
	means to deliver (including the placenta).
Urgent Care	Treatment of an unexpected Sickness or Injury that is not life threatening but requires Outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering such as high fever, a skin rash, or an ear infection, but is not an Emergency Medical Condition.

Section 14. General Exclusions and General Limitations

Although the Sandia Total Health Program provides benefits for a wide range of Covered Health Services, there are specific conditions or circumstances for which the Sandia Total Health Program will not provide benefit payments. In general, any expense that is primarily for your convenience or comfort or that of your family, caretaker, physician, or other medical provider will not be covered. For additional limitations under the Prescription Drug Program, refer to [Section 10: Prescription Drug Program](#).

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

Exclusions	Examples
Administrative fees, penalties, and limits	Charges that exceed what the Claims Administrator determines are Eligible Expenses Insurance filing fees, attorney fees, physician charges for information released to claims administrator, and other service charges and finance or interest charges Amount you pay as a result of failure to contact Kaiser Permanente for Prior Authorization or Precertification, including unauthorized care Employee Assistance Program services when you do not obtain Precertification from Kaiser Permanente Charges incurred for services rendered that are not within the scope of a provider's licensure Charges for missed appointments
Ambulance	Non-Emergency ambulance services (e.g., home to physician for an office visit)
Behavioral Health Services	Behavioral health services that are considered to be at maintenance level of care. Family therapy, including marriage counseling and bereavement counseling. Conduct disturbances unless related to a coexisting condition or diagnosis otherwise covered Educational, vocational, and/or recreational services as Outpatient procedures Biofeedback for treatment of diagnosed medical conditions Treatment for learning disabilities and pervasive Developmental Disorders (including autism) other than diagnostic evaluation Treatment for insomnia, other sleep disorders, dementia, neurological disorders, and other disorders with a known physical basis (certain treatments may be covered under medical portion of the Program)

Exclusions	Examples
Behavioral Health Services (cont.)	<p>Treatment that is determined by Kaiser Permanente to be for your personal growth or enrichment</p> <p>Court-ordered placements when such orders are inconsistent with the recommendations for treatment of a Kaiser Permanente participating provider for mental health or Kaiser Permanente Services to treat conditions that are identified by the most current edition of the Diagnostic and Statistical Manual of Mental Disorders as not being attributable to a Mental Disorder</p> <p>Sex transformations</p> <p>Any services or supplies that are not Medically Necessary</p> <p>Custodial Care</p> <p>Pastoral counseling</p> <p>Developmental Care</p> <p>Treatment for caffeine or tobacco addictions, withdrawal, or dependence</p> <p>Aversion therapies</p> <p>Treatment for codependency</p> <p>Non-abstinence-based or nutritionally-based treatment for Substance Abuse</p> <p>Services, supplies, or treatments that are covered benefits under the medical part of this Program</p> <p>Treatment or consultations provided via telephone</p> <p>Services, treatments, or supplies provided as a result of a Worker's Compensation law or similar legislation, or obtained through, or required by, any government agency or program, whether federal, state, or any subdivision, or caused by the conduct or omission of a third party for which you have a claim for damages or relief, unless you provide Kaiser Permanente with a lien against the claim for damages or relief in a form and manner satisfactory to Kaiser Permanente</p> <p>Non-organic erectile dysfunction (psychosexual dysfunction)</p> <p>Testing for ability, aptitude, intelligence, or interest</p> <p>Treatment for conduct and impulse control disorders, personality disorders, paraphilias (unusual sexual urges), and other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by Kaiser Permanente</p> <p>Services or supplies that:</p> <ul style="list-style-type: none"> Are considered Investigational, Experimental, or Unproven drugs, devices, treatments, or procedures Result from or relate to the application of such Investigational, Experimental, or Unproven drugs, devices, treatments, or procedures <p>Wilderness programs, boot camp-type programs, work camp-type programs, or recreational-type programs</p>

Exclusions	Examples
	<p>Services or supplies that are primarily for your education, training, or development of skills needed to cope with an Injury or Sicknes</p> <p>Substance Abuse benefits for Class II dependents (as defined in Sandia Total Health)</p>
Biofeedback	Biofeedback is not a Covered Health Service
Congenital Heart Disease (CHD)	<p>CHD services other than as listed below are excluded from coverage unless determined by Kaiser Permanente to be proven procedures for the involved diagnoses:</p> <p>Outpatient diagnostic testing</p> <p>Evaluation</p> <p>Surgical interventions</p> <p>Interventional cardiac catheterizations (insertion of a tubular device into the heart)</p> <p>Fetal echocardiograms (examination, measurement, and diagnosis of the heart using ultrasound technology) and</p> <p>Approved fetal interventions</p>
Dental Procedures	<p>Dental procedures are not covered under this Program except for injuries to sound, natural teeth, the jawbone, or surrounding tissue, or birth defects. Treatment must be initiated within one year of Injury.</p> <p>Dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not covered.</p>
Drugs	<p>In addition to the clinical guideline limitation imposed by Kaiser Permanente (see Section 10: Prescription Drug Program), the Program excludes coverage for certain drugs, supplies, and treatments, which include, but are not limited to, the following:</p> <p>Over-the-counter medications unless specifically included</p> <p>Fluoride preparations (other than for ages 6 months to 5 years) and dental rinses</p> <p>Contraceptive foams, jellies, and ointments</p> <p>Drugs labeled “Caution: Limited by Federal Law to Investigational use or Experimental drugs”</p> <p>Experimental drugs are defined as “a therapy that has not been or is not scientifically validated with respect to safety and efficacy.”</p> <p>Investigational drugs are defined as “those substances in any of the clinical stages of evaluation which have not been released by the Food and Drug Administration (FDA) for general use or cleared for sale in interstate commerce. It also includes those drugs that are in any of the clinical stages of evaluation (Phase I, II, and III) which have not been released by the FDA for general use or cleared for sale in interstate commerce.”</p> <p>Glucose tablets</p> <p>Drugs used for cosmetic purposes</p>

Exclusions	Examples
	<p>Prescription drugs that may be properly received without charge under local, state, or federal programs, including Workers Compensation</p> <p>Refills of prescriptions in excess of the number specified by the physician</p> <p>Refills dispensed after one year from the date of order by the physician</p> <p>Prescription Drugs purchased for those who are ineligible for coverage under the Sandia Total Health Program</p> <p>Prescription Drugs taken by a donor who is not insured under the Sandia Total Health Program</p> <p>Medicine not Medically Necessary for the treatment of a disease or an Injury</p>
Drugs (cont.)	<p>The following are excluded by the Prescription Drug Program but may be covered by Kaiser Permanente if Medically Necessary:</p> <p>Ostomy supplies</p> <p>Blood glucose meters</p> <p>Implantable birth control devices such IUDs (Covered under Family Planning)</p> <p>Allergy serum</p> <p>External Insulin pumps and supplies</p> <p>Continuous glucose monitoring systems and supplies</p> <p>Medication that is dispensed and/or administered by a licensed facility or provider such as a hospital, home health care agency, or physician's office, and the charges are included in the facility or provider bill to Kaiser Permanente</p>
Equipment	<p>Exercise equipment (e.g., exercycles, weights, etc.)</p> <p>Hearing aids for hearing loss for members and dependents age 21 and over (see benefit under hearing aids for Sickness and Injury coverage)</p> <p>Braces prescribed to prevent injuries while you are participating in athletic activities</p> <p>Household items, including, but not limited to</p> <p>Air cleaners and/or humidifiers</p> <p>Bathing apparatus</p> <p>Scales or calorie counters</p> <p>Blood pressure kits</p> <p>Water beds</p> <p>Personal items, including, but not limited to</p> <p>Support hose, except Medically Necessary surgical or compression stockings</p> <p>Foam cushions</p> <p>Pajamas</p> <p>Equipment rental fees above the purchase price, with the exception of oxygen equipment</p>

Exclusions	Examples
Genetic Testing/ Counseling	Investigational, Experimental, or Unproven genetic testing is not covered. In addition, genetic counseling, including service for evaluation and explaining the implications of genetic, or inherited disease, whether provided by physicians or non-physician health professionals, for the interpretation of family and medical histories to assess the risk of disease occurrence or recurrence, and for assisting in making treatment decisions based upon the risk of disease occurrence or recurrence is not covered. Refer to Genetic Testing/Counseling and Preventive Care for covered services.
Hospital fees	Expenses incurred in any federal hospital, unless you are legally obligated to pay Hospital room and board charges in excess of the semi-private room rate unless Medically Necessary and approved by Kaiser Permanente In-hospital personal charges (e.g., telephone, barber, TV service, toothbrushes, slippers)
Hypnotherapy	Hypnotherapy is not a Covered Health Service
Infertility, Reproductive, and Family Planning	Purchase of eggs Services related to or provided to anonymous donors Services provided by a doula (labor aide) Storing and preserving sperm Donor expenses related to donating eggs/sperm (including prescription drugs); however, charges to extract the eggs from a covered employee for a donor are allowed Expenses incurred by surrogate mothers Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes Over-the-counter medications for birth control/prevention Parenting, pre-natal, or birthing classes
Investigational, Experimental, or Unproven treatment	Investigational, Experimental, or Unproven Services, unless the Sandia Total Health Program has agreed to cover them in Section 14, Coverages/Limitations. Note: This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices, or pharmacological regimens are the only available treatment option for your condition. Note: This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which benefits are provided as described under clinical trials.
Miscellaneous	Eye exams except for Vision exams (refractions) which are covered and except as outlined under Section 7, Benefits. Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) or visual training.

Exclusions	Examples
	<p>Modifications to vehicles and houses for wheelchair access</p> <p>Health club memberships and programs or spa treatments</p> <p>Treatment or services</p> <p>Incurred when the patient was not covered under this Program even if the medical condition being treated began before the date your coverage under the Program ends</p> <p>For Sickness or Injury resulting from your intentional acts of aggression, including armed aggression, except for injuries inflicted on an innocent bystander (e.g., you did not start the act of aggression)</p> <p>For job-incurred Injury or illness for which payments are payable under any Workers Compensation Act, Occupational Disease Law, or similar law</p> <p>While on active military duty</p> <p>That are reimbursable through any public program other than Medicare or through no-fault automobile insurance</p> <p>Charges in connection with surgical procedures for sex changes</p> <p>Charges for blood or blood plasma that is replaced by or for the patient</p> <p>Conditions resulting from insurrection, except for injuries inflicted on an innocent bystander who is covered under this Program</p> <p>Christian Science practitioners and facilities</p> <p>Food of any kind (except for Special Oral Foods which would be covered)</p> <p>Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk (except for Special Oral Foods which would be covered)</p> <p>Foods to control weight, treat obesity (including liquid diets), lower cholesterol, or control diabetes</p> <p>Oral vitamins and minerals (with the exception of certain prescription vitamins) as outlined in Section 8, Prescription Drug Program</p> <p>Herbs and over-the-counter medications except as specifically allowed under the Program</p> <p>Charges prohibited by federal anti-kickback or self-referral statutes</p> <p>Chelation therapy, except to treat heavy metal poisoning</p> <p>Diagnostic tests that are:</p> <p>Delivered in other than a physician's office or health care facility</p> <p>Self-administered home-diagnostic tests, including, but not limited to, HIV and pregnancy tests</p> <p>Domiciliary care</p> <p>Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for ten seconds or longer). Appliances for snoring are always excluded.</p>

Exclusions	Examples
	<p>Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments when:</p> <ul style="list-style-type: none"> Required solely for purposes of career, education, camp, employment, insurance, marriage or adoption; or as a result of incarceration Conducted for purposes of medical research Related to judicial or administrative proceedings or orders or Required to obtain or maintain a license of any type Private duty nursing received on an inpatient basis Respite care (with the exception of hospice related respite care) Rest cures Shoe inserts, orthotics (except for care of the diabetic foot), and orthopedic shoes (except when an orthopedic shoe is joined to a brace). Storage of blood, umbilical cord, or other material for use in a Covered Health Service, except if needed for an imminent surgery
<p>Not a Covered Health Service and/ or not Medically Necessary</p>	<p>Health Services, including services and supplies which are :</p> <ul style="list-style-type: none"> Not provided for the purpose of preventing, diagnosing or treating Sickness, Injury, mental illness, Substance Abuse or their symptoms; Not Medically Necessary; Not consistent with nationally recognized scientific evidence, as available, and prevailing medical standards and clinical guidelines; For the convenience of the covered person, physician, facility or any other person; Included in Section 11 General Exclusion and Limitations Provided to a covered person who does not meets the Program's eligibility requirements; and Identified in general program exclusions.
<p>Old claims</p>	<p>Claims received one year after the date charges are incurred</p>
<p>Physical Appearance</p>	<p>Breast reduction/augmentation surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which the claims administrator determines is requested to treat a physiologic functional impairment or coverage required by the Women's Health and Cancer Right's Act of 1998.</p> <p>Any loss, expense, or charge that results from cosmetic or reconstructive surgery, except after breast cancer. Exceptions to this exclusion include:</p> <ul style="list-style-type: none"> Repair of defects that result from surgery for which you were paid benefits under the policy Reconstructive (not cosmetic) repair of a congenital defect that materially corrects a bodily malfunction. <p>Note: For the purposes of this exclusion, poor self-image or emotional or psychological distress does not constitute a bodily malfunction.</p> <ul style="list-style-type: none"> Liposuction Pharmacological regimens

Exclusions	Examples
	<p>Nutritional procedures or treatments (except for nutrition visits)</p> <p>Tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery, and other such skin abrasion procedures)</p> <p>Replacement of an existing intact breast implant unless there is documented evidence of silicon leakage</p> <p>Physical conditioning programs, such as athletic training, body building, exercise, fitness, flexibility, and diversion or general motivation</p> <p>Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity</p> <p>Wigs regardless of the reason for hair loss</p> <p>Treatments for hair loss</p>
Providers	<p>Services:</p> <p>Performed by a provider who is a family member by birth or marriage, including your spouse, brother, sister, parent, or child</p> <p>A provider may perform on himself or herself</p> <p>Performed by a provider with your same legal residence</p> <p>Provided at a diagnostic facility (hospital or otherwise) without a written order from a provider</p> <p>Ordered by a provider affiliated with a diagnostic facility (hospital or otherwise) when that provider is not actively involved in your medical care</p> <p>Prior to ordering the service or</p> <p>After the service is received</p> <p>This exclusion does not apply to mammography testing.</p>
Services, supplies, therapy, or treatments	<p>Charges that are:</p> <p>Custodial in nature</p> <p>Otherwise free of charge to you</p> <p>Furnished under an alternative medical program provided by Sandia</p> <p>For aromatherapy or rolfing (holistic tissue massage)</p> <p>For Developmental Care after a maintenance level of care has been reached</p> <p>For Maintenance Care</p> <p>For massage therapy unless performed by a licensed chiropractor, physical therapist, or physician as a manual therapy technique for lymphatic drainage</p> <p>Educational therapy when not Medically Necessary</p> <p>Educational testing</p> <p>Paid Smoking-cessation programs. Note: Tobacco Use and Tobacco-Caused Disease Counseling covered as described within the "Preventive Service" section.</p> <p>Services, other than Emergency Services, received outside the United States whether or not the Services are available in the United States</p> <p>Surgery and other related treatment that is intended to correct</p>

Exclusions	Examples
	nearsightedness, farsightedness, presbyopia, and astigmatism, including but not limited to procedures such as laser and other refractive eye surgery and radial keratotomy
Surgical and nonsurgical treatment for obesity	<p>Treatment for over-the-counter appetite control, food addictions, or eating disorders that are not documented cases of bulimia or anorexia meeting standard diagnostic criteria as determined by Kaiser Permanente</p> <p>The following treatments for obesity:</p> <p>Non-surgical treatment, even if for morbid obesity (except for nutrition treatments), and</p> <p>Surgical operations for the correction of morbid obesity determined by Kaiser Permanente not to be Medically Necessary to preserve the life or health of the member</p>
Transplants	<p>Health services for organ and tissue transplants except as identified under Organ Transplants in Section 7, Benefits, unless Kaiser Permanente determines the transplant to be appropriate according to Kaiser Permanente transplant guidelines.</p> <p>Determined by Kaiser Permanente not to be Unproven procedures for the involved diagnoses</p> <p>Not consistent with the diagnosis of the condition</p> <p>Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available)</p> <p>Donor costs for organ or tissue transplantation to another person unless the recipient is covered under this Program</p>
Transportation	<p>Non-Emergency ambulance services are not covered.</p> <p>Transportation, except ground ambulance and air ambulance services as outlined in Section 11, General Exclusion and General Limitations</p>
Travel	Travel or transportation expenses, even if ordered by a physician, except as identified under Travel and Lodging in Section 4, Deductibles, Out-of-Pocket Maximums, and Lifetime Maximums
War	Any disease or injury resulting from a war, declared or not, any military duty, or any release of nuclear energy. Also excluded are charges for services directly related to military service provided or available from the Veterans' Administration or military medical facilities as required by law.

Section 16. Coordination of Benefits (COB)

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

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

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

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

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

plan's payment arrangements shall be the Covered Health Expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or Service for a payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Covered Health Expense used by the secondary plan to determine its benefits.

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

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

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

Refer to [Section 10: Prescription Drug Program](#) for information on eligibility to use the Prescription Drug Program, as well as how COB works, if your covered family member has other insurance coverage.

Section 17. Binding Arbitration

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

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

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

Scope of Arbitration

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

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

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

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

"Kaiser Permanente Parties" include:

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

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

Initiating Arbitration

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

Serving Demand for Arbitration

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

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

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

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

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

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

Filing Fee

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

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

Number of Arbitrators

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

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

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

Payment of Arbitrators' Fees and Expenses

Kaiser Foundation Health Plan, Inc. will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* ("Rules of

Procedure"). In all other arbitrations, the fees and expenses of the neutral arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

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

Costs

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

Rules of Procedure

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

General Provisions

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

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

Arbitrations shall be governed by this "Binding Arbitration for Members and Dependents Assigned to the Kaiser Permanente Northern California Region" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to

arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this “Binding Arbitration for Members and Dependents Assigned to the Kaiser Permanente Northern California Region” section.

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

Arbitration Agreement

All members and dependents agree to the following arbitration language:

I understand that if I am assigned to the Kaiser Permanente Northern California Region or Southern California Region, then except for Small Claims Court cases, cases subject to a Medicare appeals procedure, and certain benefit-related disputes, any dispute between myself, my heirs or relatives, or other associated parties on the one hand and Kaiser Permanente Parties on the other hand (Kaiser Permanente Insurance Company, Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, The Permanente Medical Group, the Southern California Permanente Medical Group, or other associated parties), for alleged violation of any duty relating to or arising from a relationship to any of the Kaiser Permanente Parties as a participant in this medical plan, a member, or a patient, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the delivery of services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the summary plan description.

Section 18. Claims and Appeals

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

Timing of Claim Determinations

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

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

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

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

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

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

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

* All listed time frames are calendar days

Concurrent Care Claims

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

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

Post Service Claims

To obtain payment for Services you have paid for or to obtain review of a claims payment decision, you must follow the procedures outlined in this “

Arbitration Agreement

All members and dependents agree to the following arbitration language:

I understand that if I am assigned to the Kaiser Permanente Northern California Region or Southern California Region, then except for Small Claims Court cases, cases subject to a Medicare appeals procedure, and certain benefit-related disputes, any dispute between myself, my heirs or relatives, or other associated parties on the one hand and Kaiser Permanente Parties on the other hand (Kaiser Permanente Insurance Company, Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, The Permanente Medical Group, the Southern California Permanente Medical Group, or other associated parties), for alleged violation of any duty relating to or arising from a relationship to any of the Kaiser Permanente Parties as a participant in this medical plan, a member, or a patient, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the delivery of services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the summary plan description.

If you miss a deadline for filing a claim or appeal, review may be declined. Before You can file a civil action under ERISA section 502(a)(1)(B), you must meet any deadlines and exhaust the claims and appeals procedures set forth in this .

How to File a Claim

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

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

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

IMPORTANT: All claims must be submitted within one year from the date of service in order to be eligible for consideration of payment. This one-year requirement will not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends. It is recommended that claims be submitted as soon as possible after the medical or prescription expenses are incurred.. If you need assistance in filing a claim, call Kaiser General Member Service at 1-800-663-1771.

Your claim must include all of the following information:

- Patient name, address, and Kaiser Permanente ID card medical or health record number
- Date(s) of service
- Diagnosis
- Procedure codes and description of the Services
- Charges for each Service
- The name, address, and tax identification number of the provider

- The date the injury or illness began
- Any information regarding other medical coverage

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

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

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

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

If a Claim Is Denied

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

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

- The notice will also contain a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination following completion of all levels of review.
- **Note:** You have the right to request any diagnostic and treatment codes and their meanings that may be the subject of your claim. To make such a request, contact Customer Service at the number on your identification card.

How to Appeal a Denied Claim

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

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

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

To appeal a pharmacy claim, submit your form to:

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

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

In addition states with Consumer Assistance Programs under PHS ACT Section 279.3 may be available in your state to assist you in filing your appeal. A list of state Consumer Protection Agencies is available on KP.org (Log into My Health Manager, select Manage My Plan & Coverage, then click on Claims Summary list of the State Assistance Programs is listed under the Resources banner).

Deemed Exhaustion

If the Program does not adhere to the Federal Appeals process as described below, it will be deemed that you have exhausted the appeals process. This means that you are no longer required to stay within the mandated internal appeal process. Exception:

- Violations which do not cause and are not likely to cause prejudice or harm and,
- Can be demonstrated were for good cause or due to matters beyond the control of the Plan and,

- The violation occurred in the context of an on-going, good faith exchange of information between the Program and you.

You may request a written explanation of the violation and it will be provided to you within 10 days of your request. Such explanation will include a specific description of the basis, if any, on which the appeal process is not deemed to be exhausted. If an external review organization or court determines your appeal is not deemed exhausted, you have the right to resubmit your appeal request and continue the internal appeal process.

Procedures on Appeal

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

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

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

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

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

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

Benefits for an ongoing course of treatment will not be reduced or terminated while an appeal is pending. However, if the appeal is denied in whole or in part, you may be financially responsible for the cost of the denied portion.

Timing of Initial Appeal Determinations

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

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

* All listed time frames are calendar days

Notice of Determination on Initial Appeal

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

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

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

How to File a Final Appeal

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

Send the written request to:

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

Or fax your appeal to 614-212-7110

To appeal a pharmacy claim, submit your form to:

Kaiser Permanente
Attn: SFAS National Self-Funding
3840 Murphy Canyon Rd
San Diego, CA 92123

Or fax your appeal to 858-614-7912

Timing of Final Appeal Determinations

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

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

* All listed time frames are calendar days

Notice of Determination on Final Appeal

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

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

- The reasons for the denial, including references to specific the Program provisions upon which the denial was based.
- That you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (other than legally or medically privileged documents) relevant to your claim for benefits.

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

Next Steps

If after exhausting the appeals process, you are still not satisfied, your remaining remedies include the right to bring suit in Federal Court under Section 502(a) of ERISA and voluntary dispute resolution options, such as mediation or independent External Review as described below.

External Review

Your request for external review **must be filed within four months** after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

To request an independent external review of Plan denials, complete the External Review request form on kp.org and send the written request to:

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

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

Preliminary Review of External Review Request

Within five business days following the date of receipt of the external review request, KPIC will complete a preliminary review of the request to determine whether:

- (a) The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
- (b) The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
- (c) The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process; and
- (d) The claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, KPIC will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, the notification will describe the information or materials needed to make the request complete and KPIC will allow the claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

Referral to Independent Review Organization

KPIC will assign an independent review organization (IRO) that is accredited by URAC or by similar nationally-recognized accrediting organization to conduct the external review. Moreover, KPIC will take action to guard against bias and to ensure independence. Accordingly, KPIC will maintain contracts with at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO will not be eligible for any financial incentives based on the likelihood that the IRO will support a denial of benefits.

Contracts between KPIC and IROs will provide for the following:

- (a) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.
- (b) The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO consider when conducting the

external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

(c) Within five business days after the date of assignment of the IRO, KPIC will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by KPIC to timely provide the documents and information will not delay the conduct of the external review. If KPIC fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making its decision, the IRO will notify the claimant and KPIC of that decision.

(d) Upon receipt of any information submitted by the claimant, the IRO will within one business day forward the information to KPIC. Upon receipt of any such information, KPIC may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by KPIC will not delay the external review. The external review may be terminated as a result of the reconsideration only if KPIC decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, KPIC will provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO will terminate the external review upon receipt of the notice from KPIC.

(e) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the internal claims and appeals process applicable under section 2719 of the PHS Act. In addition to the document and information provided, the assigned IRO, to the extent information or documents is available and the assigned IRO considers them appropriate, the IRO will consider the following in reaching a decision:

- The claimant's medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan, claimant or the claimant's treating provider;
- The terms of the claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which will include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the Plan, the criteria are inconsistent with the terms of the Plan or with applicable law; and

- The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(f) The assigned IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO will deliver the notice of final external review decision to the claimant and the Plan.

(g) The assigned IRO's decision notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning (if applicable), the treatment code and its corresponding meaning (if applicable), and the reason for the previous denial);
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision.
- References to the documentation considered, including the specific coverage provision and evidence-based standards considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards, that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to the claimant;
- A statement that judicial review may be available to the claimant; and
- Current contact information, including phone number, for any applicable ombudsman established under the PHS Act of 2793.

(h) After a final external review decision, the IRO will retain records of all claims and notices associated with the external review process for six years; The IRO will make such records available for examination by the claimant, Plan or Federal oversight agency upon request, except where such disclosure would violate Federal privacy laws.

Reversal of Plan's Decision

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, KPIC will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim as directed by the IRO.

Expedited External Review

If after exhausting of the internal Urgent Appeal process, you are still not satisfied, You may be eligible for an expedited external appeal.

Request for Expedited External Review

KPIC will allow a claimant to make a request for an expedited external review at the time the claimant receives:

(a) An adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal or

(b) A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Preliminary Review

Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the claimant or its eligibility determination.

Referral to Independent Review Organization

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

Notice of Final External Review Decision

The Plan's contract with the assigned IRO requires the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that

notice, the assigned IRO will provide written confirmation of the decision to the claimant and Plan.

Your Claim after External Review

You may have certain additional rights if you remain dissatisfied after you have exhausted all levels of review including external review. If you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272). Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court.

Section 19. Service Areas

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

Service Areas by County & ZIP Code for Northern California

County	ZIP Code
Alameda	(Whole County)
Amador (Partial County)	95640, 95669
Contra Costa	(Whole County)
El Dorado (Partial County)	95613-14, 95619, 95623, 95633-35, 95651, 95664, 95667, 95672, 95682, 95762
Fresno (Partial County)	93242, 93602, 93606-07, 93609, 93611-13, 93616, 93618-19, 93624-27, 93630-31, 93646, 93648-52, 93654, 93656-57, 93660, 93662, 93667-68, 93675, 93701-12, 93714-18, 93720-30, 93737, 93740-41, 93744-45, 93747, 93750, 93755, 93760-61, 93764-65, 93771-79, 93786, 93790-94, 93844, 93888
Kings (Partial County)	93230, 93232, 93242, 93631, 93656
Madera (Partial County)	93601-02, 93604, 93614, 93623, 93626, 93636-39, 93643-45, 93653, 93669, 93720
Marin	(Whole County)
Mariposa (Partial County)	93601, 93623, 93653
Napa (Partial County)	94503, 94508, 94515, 94558-59, 94562, 94567*, 94573-74, 94576, 94581, 94589-90, 94599, 95476 *Knoxville is not in the Service Area.
Placer (Partial County)	95602-04, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677-78, 95681, 95692, 95703, 95722, 95736, 95746-47, 95765
Sacramento	(Whole County)
San Francisco	(Whole County)
San Joaquin	(Whole County)
San Mateo	(Whole County)
Santa Clara (Partial County)	94022-24, 94035, 94039-43, 94085-89, 94301-06, 94309, 94550, 95002, 95008-09, 95011, 95013-15, 95020-21, 95026, 95030-33, 95035-38, 95042, 95044, 95046, 95050-56, 95070-71, 95076, 95101, 95103, 95106, 95108-13, 95115-36, 95138-41, 95148, 95150-61, 95164, 95170, 95172-

	73, 95190-94, 95196
Solano	(Whole County)
Sonoma (Partial County)	94515, 94922-23, 94926-28, 94931, 94951-55, 94972, 94975, 94999, 95401-07, 95409, 95416, 95419, 95421, 95425, 95430-31, 95433, 95436, 95439, 95441-42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471-73, 95476, 95486-87, 95492
Stanislaus	(Whole County)
Sutter (Partial County)	95626, 95645, 95648, 95659, 95668, 95674, 95676, 95692, 95836-37
Tulare (Partial County)	93238, 93261, 93618, 93631, 93646, 93654, 93666, 93673
Yolo (Partial County)	95605, 95607, 95612, 95616-18, 95645, 95691, 95694-95, 95697-98, 95776, 95798-99
Yuba (Partial County)	95692, 95903, 95961

Section 20. Customer Service Phone Numbers

General Member Service
Northern California Region
800-663-1771

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

Advice Nurses
Northern California Region
866-454-8855

Interpreter Services
Northern California Region
800-663-1771

TTY: 771

Pharmacy Benefit Information
All Regions
866-427-7701

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

Health Care Flexible Spending Account (HCFSA) & Health Reimbursement Account (HRA) Administrator

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

7:00 am – 9:00 pm CST, M-F