Sandia National Labs Total Health Plan (PPO) Choice Plus Network **Administered by:** UnitedHealthcare

Summary only — lists the deductible amounts, health care account limit, out-of-pocket limit amounts, and member coinsurance percentages of the Sandia National Labs Total Health Plan. These plan details are applicable for the 2026 plan year only and are subject to change.

Sandia National Labs Total Health Plan – Certain services have maximum annual limits or lifetime maximum benefits.	**Member's Share of Covered Charges**		
	**** Tier 1 (In-Network)[1,2]**	**Tier 2 (In-Network)[1,2]**	**Tier 3 (Out-of-Network)[1,2]**
Calendar Year Deductible: Excludes prescription drugs and preventive services	$600 Individual Up to $1,200 Two-Party Up to $1,200 EE + Children Up to $1,800 Family	$850 Individual Up to $1,700 Two-Party Up to $1,700 EE +Children Up to $2,550 Family	$2,500 Individual Up to $5,000 Two-Party Up to $5,000 EE + Children Up to $7,500 Family
Flexible Spending Account (FSA): Administered by Inspira Financial – If enrolled, these funds will be used first to pay for any eligible expenses; then remaining funds from your Health Reimbursement Account are applied.			
Health Reimbursement Account (HRA): Administered by Inspira Financial - Used to offset medical plan costs. Contact Inspira Financial at https://openenrollment.inspirafinancial.com/inspira/Sandia_PayFlex to get more information on your HRA. Funded by Sandia. Learn more at hr.sandia.gov	$500 Individual $750 Two-Party OR EE + Children $1,000 EE + Spouse $1,250 Family Primary covered members and their spouse (if enrolled as a dependent) must complete the Health Assessment, Health Action Plan and other healthy activities to earn money for the HRA		
Sandia Clinic	No Charge to Employees 0% Coinsurance (deductible waived) for services available at On-Site Clinic		
Calendar Year Out-of-Pocket Limit: Includes deductible and coinsurance only, NOT penalty amounts, amount in excess of covered charges, or noncovered charges[2] Excludes prescription drugs	$2,250 Individual Up to $4,500 Two-Party Up to $4,500 EE + Children Up to $6,750 Family	$3,000 Individual Up to $6,000 Two-Party Up to $6,000 EE + Children Up to $9,000 Family	$7,500 Individual Up to $15,000 Two-Party Up to $15,000 EE + Children Up to $22,500 Family
Prescription Out of Pocket Maximum	$1,500 per Individual up to a maximum of $5,950		No out-of-pocket maximum
Office Services (non-preventive): includes office visits, medication management, family planning, evaluations, medical eye exam, surgery, therapeutic injections; allergy injections, tests, serum **Virtual Visits – Teladoc, Doctor On Demand, Amwell**	10% $10 Copay Deductible Waived	20% $10 Copay Deductible Waived	40% Not Covered
Acupuncture Treatment (max. **$750**/calendar year – max. applies to In and Out of Network services)	Not Applicable	20%	40%
Ambulance Services: Ground and Emergency Air Transport	Not Applicable	20%[3]	
Ambulance Services: Nonemergency Air Transfer ($300 penalty if prior auth is not obtained)	Not Applicable	20%	40%[4]
Behavioral Health: Mental Health, Behavioral Health, or Substance Abuse Services (outpatient/office/IOP, including partial hospitalization, Residential Treatment Center and virtual visits); family and marriage counseling NOT covered except under EAP	Not Applicable	100% after deductible is met	40%[4]
Emergency Room Treatment	$250 Copay per visit (waived if admiitted)		
Urgent Care Facility	Not Applicable	20%	
Out-of-Country	NOT COVERED	Emergency and Urgent Care 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 benefit level.	

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	**** Tier 1 (In-Network)[1,2]**	**Tier 2 (In-Network)[1,2]**	**Tier 3 (Out-of-Network) [1,2]**
Enteral Nutrition/Nutritional Supplements (for diagnosis of dysphagia, as the sole source of nutrition, for RH Factor disorder, PKU, terminal cancer)	Not Applicable	20%	40%[4]
Eye Exam/Glasses/Contacts (non-refractive care due to sudden illness or injury to eye such as conjunctivitis, diabetic retinopathy, glaucoma, cataracts: glasses and contacts only when needed due to the loss of a natural lens/cataract surgery)	Not Applicable	20%	40%
Family Planning (includes sterilization and its REVERSAL, Depo-Provera, IUDs, ultrasounds and laparoscopies, pregnancy termination, including elective abortion)	Not Applicable	20%	40%
Hearing Aids and Related Services (required due to illness or injury ONLY); initial hearing aid only	Not Applicable	20%	40%[4]
Hearing Aids and Related Services for dependent children under age 21 ONLY: one (1) hearing aid per hearing-impaired ear, every 36 months, includes ear molds as necessary, fitting and dispensing services.	Not Applicable	20%	40%
Home Health Care/Home I.V. Services	Not Applicable	20%	40%[4]
Hospice Services	Not Applicable	20%	40%[4]
Infertility Treatment (max. **$45,000** lifetime; includes GIFT, insemination, storage, egg retrieval, etc.	Not Applicable	20%[4]	40%[4]
Inpatient Hospital/Facility Services			
Medical/Surgical (Maternity-Related Room and Board and Covered Ancillaries)	10%	20%	40%[4]
Routine Nursery Care for Covered Newborns	10%	20%	40%
Lab, X-Ray, MRI, CT, PET Scans, Other Diagnostic Tests (First diagnostic colonoscopy, mammogram and breast ultrasound covered at 100%)	Physician's Office, Diagnostic Centers, Independent Labs, and Ambulatory Surgical Centers 10% Facility 20%		40%[4]
Maternity Services, including Routine Pediatrician Care for Covered Newborns	Office Visits, Childbirth/delivery professional services10%	20%	40%[4]
Obesity Surgery (for members with a BMI of 35.39 and one or more co-morbid medical condition or a SMI equal or greater than 40)	10%	20%	40%[4]
Outpatient Facility/Physician (including surgical procedures related to pregnancy and family planning, nonroutine colonoscopies, excluding first diagnostic colonoscopy which is covered at 100%)	Facility Not Applicable Physician Surgical Fees 10%	20%	40%[4]
Prescription Drugs/Diabetic Supplies	See separately issued Optum Rx Drug Plan Rider		
Preventive Services: Adult medical care/routine exams; well childcare; routine lab and X-ray; vision **(not an exam/refraction**) and hearing screening; mammogram, routine colonoscopy. Strict guidelines. Allow barium enema in place of colonoscopy as well. Pay sports physicals. If Sandia's onsite clinic refers EE to get immunization off-site, pay as in-network.	No Charge	No Charge	40%

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	**** Tier 1 (In-Network)[1,2]**	**Tier 2 (In-Network)[1,2]**	**Tier 3 (Out-of-Network) [1,2]**
Prosthetics and Orthotics	Not Applicable	20%[5]	40%[4,5]
Short-Term Rehabilitation: Includes inpatient rehabilitation facility; skilled nursing facility, outpatient physical, occupational, and speech therapy services.	Not Applicable	20%	40%[4]
Smoking Cessation	SEE PREVENTIVE SERVICES FOR BENEFIT		40%
Spinal Manipulation (max. **$750**/calendar year; based on provider type – max. applies to In and Out of Network services)	Not Applicable	20%	40%
Supplies and Durable Medical Equipment	Not Applicable	20%[5]	40%[4,5]
Therapy: Chemotherapy, Dialysis, and Radiation Therapy	Not Applicable	20%	40%[4]
Urgent Care Facility	Not Applicable	20%	40%
Transplants: Heart, Heart-Lung, Liver, Liver-Kidney, Liver-Intestine, Lung, Kidney, Pancreas Only, Intestinal, Pancreas-Kidney, Bone Marrow and Peripheral Stem Cell, (w/ or w/o high-dose chemotherapy): $25,000 (lifetime maximum) for bone marrow search.	Not Applicable	20%	40%[4]
Travel, Food, and Lodging: Per diem for lodging/meals combined = $50 for patient and $100 for patient and one companion ONLY if patient lives more than 50 miles from facility. Travel may include airfare, taxi/ground, mileage reimbursement at IRS rate. Covered for transplants only. **Covered only if member uses a Center of Excellence, Transplant Access Program or a UHC Network for Transplants, Congenital Heart Disease, or Cancer Treatment**	Combined overall maximum of $10,000 per member for all combined for entire life. This benefit is NOT available unless member uses a Center of Excellence, Transplant Access Program or a UHC Network provider.		

This chart is a summary. It does not explain maximums, exclusions, or limitations, nor does it list all benefits and cost sharing. For a complete description of your Plan, please refer to the UHC Benefit Summary on hr.sandia.gov. This chart highlights key features of Sandia's benefits. The terms of your benefit plans are governed by legal documents. If there are inconsistencies between information in this chart and the legal plan documents, then the legal plan documents are the final authority.

FOOTNOTES:

[1] The initial covered charges that are incurred in a calendar year are applied to the calendar year deductible. The deductible must be met before benefit payments are made; excluding preventive services (except for out-of-network preventive care) and prescription drug copays reimbursed to you that were obtained through Optum Rx. Tier 1 In-Network and Tier 2 In-Network deductible amounts DO cross-apply.

[2] After a member reaches the out-of-pocket limit, UnitedHealthcare pays 100 percent of the allowed amount of that member's covered charges. Out-of-pocket amounts do not cross-apply between In-Network and Out-of-Network Provider benefit levels. However, Tier 1 (In-Network) and Tier 2 (In-Network) out-of-pocket amounts DO cross-apply.

[3] Initial treatment of a medical emergency is paid at the In-Network (Tier 2) level when you receive services from an In-Network or Out-of-Network Provider. Follow-up treatment and treatment that is not for an emergency is paid at the applicable network level.

[4] Preauthorization is required Out-of-Network or benefit will have a $300 penalty applied.

[5] Rental benefits for medical equipment and other items will not exceed the purchase price of a new unit. Preauthorization Out-of-Network is required for medical equipment and other items over $1,000 (purchased or cumulative rental value).

**No Tier 1 providers in CA