Sandia National Labs Health Savings Plan (Choice Plus HSA)

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 Health Savings Plan. These plan details are applicable for the 2025 plan year only and are subject to change.

Sandia Health Savings Plan – There is no lifetime maximum benefit. However, certain services have maximum annual limits.	**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	$1,650 Individual $3,300 Family	$1,650 Individual $3,300 Family	$3,250 Individual $6,500 Family
Health Savings Account (HSA): HSA is administered by Optum			
Sandia Contribution to HSA for Active Employees Only	Individual: Matching contributions up to $600 maximum match by Sandia	Family: Matching contributions up to $1,000 maximum match by Sandia	
Maximum HSA Contributions (all sources)	$4,300 in 2025 $1,000 catch-up (age 55+)	$8,500 in 2025 $1,000 catch-up (age 55+)	
Sandia Clinic	Employees pay based on fee schedule until annual deductible is met, then free for remainder of calendar year. 0% Coinsurance for services available at On-Site Clinic		
Calendar Year Out-of-Pocket Limit: Includes deductible, coinsurance and prescription drugs; NOT penalty amounts, amount in excess of covered charges, or noncovered charges.[2]	$3,200 Individual $9,200 Family	$3,200 Individual $9,200 Family	$6,500 Individual $19,500 Family
Office Services (non-preventive): includes office visits, medication management, family planning, evaluations, medical eye exam, surgery, therapeutic injections; allergy injections, tests, serum. **Virtual Visits – Galileo, Teladoc, Doctor On Demand, Amwell**	10% $10 Copay after Deductible	20% $10 Copay after Deductible	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 and 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 level of benefit.	

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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%[4]
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%	40%[4]
Inpatient Hospital/Facility Services			
Medical/Surgical (Maternity-Related Room and Board and Covered Ancillaries)	Office Visits, Childbirth/delivery professional services 10%	20%	40%[4]
Routine Nursery Care for Covered Newborns	10%	20%	40%
Lab, X-Ray, MRI, CT, PET Scans, Other Diagnostic Tests	Physician's Office, Diagnostic Centers, Independent Labs, and Ambulatory Surgical Centers 10%	20%	40%[4]
Maternity Services, including Routine Pediatrician Care for Covered Newborns	Office 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)	Facility Not Applicable Physician Surgical Fees 10%	20%	40%[4]
Prescription Drugs/Diabetic Supplies	See separately issued Express Scripts Drug Plan Rider		

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	**** Tier 1 (In-Network)[1,2]**	**Tier 2 (In-Network)[1,2]**	**Tier 3 (Out-of-Network)[1,2]**
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%
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 (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.		

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). 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 maximum of that member's covered charges, whichever is applicable. 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