Sandia National Laboratories

2009 Medical Plans Comparison Chart for Non-Medicare Retirees

	UnitedHealthcare Premier PPO		CIGNA In-Network Plan	Kaiser (CA) HMO
Type of Plan	Preferred Provider Organization – PPO		Exclusive Provider Organization (EPO) (An HMO "Look - Alike")	Health Maintenance Organization – HMO
	In-Network	Out-of-Network	In-Network	In-Network Only
Annual Calendar Year Deductible	Individual: $250 Family: $750	Individual: $750 Family: $2,250	Individual: None Family: None	Individual: None Family: None
Annual Calendar Year Out-of-Pocket Maximum	Individual: $1,750 Family: $3,500	Individual: $3,500 Family: $7,000	Individual: $1,500 Family: $3,000	Individual: $1,500 Family: $3,000 (two or more) Member is responsible for tracking annual out-of-pocket costs through accumulation of Kaiser receipts (excludes prescription copays)
Preventive Care				
Annual Routine Physical	No Charge	30% of U&C Subject to deductible	No copay	$20 copay
Immunizations/Flu Shots				No copay
Certain Cancer Screenings				No copay
Outpatient Services				
Office Visit – PCP	$20 copay Lab, radiology, supplies, diagnostic tests and injections, other than immunizations, performed in a physician's office will result in a 15% coinsurance which is subject to deductible	30% of U&C Subject to deductible	$20 copay	$20 copay
Office Visit – Specialist	$35 copay Lab, radiology, supplies, diagnostic tests and injections, other than immunizations, performed in a physician's office will result in a 15% coinsurance which is subject to deductible		$30 copay	$20 copay
Urgent Care	15% of negotiated fees Subject to deductible	30% of U&C Subject to deductible	$40 copay	$20 copay
Emergency Room			$125 per visit	$100 per visit
Outpatient Surgery			$125 copay	$100 copay per procedure
Allergy Treatment • Testing			$30 copay	$20 copay
• Serum			No copay	No copay
• Shot Only			$10 copay	$5 copay
Chiropractic	15% of negotiated fees Subject to deductible $1000 maximum combined in and out of network	30% of U&C Subject to deductible $1000 maximum combined in and out of network	$20 copay Combined maximum of 60 visits/calendar year for Chiropractic, Acupuncture, Speech Therapy, Physical Therapy, and Occupational Therapy	$15 copay Chiropractic care with a maximum of 30 visits/CY
Acupuncture	15% of negotiated fees Subject to deductible $1000 maximum combined in and out of network	30% of U&C Subject to deductible $1000 maximum combined in and out of network		$20 copay Acupuncture allowed with referral for Medical Management of Chronic Pain only
Speech, Physical/ Occupational Therapy	15% of negotiated fees Subject to deductible	30% of U&C Subject to deductible		$20 copay Maximum of 60 consecutive days/condition/lifetime
Lab/Radiology (Outpatient)	15% of negotiated fees Subject to deductible	30% of U&C Subject to deductible	No copay	No copay

	UnitedHealthcare Premier PPO		CIGNA In-Network Plan	Kaiser (CA) HMO
Type of Plan	**Preferred Provider Organization – PPO**		**Exclusive Provider Organization (EPO) (An HMO “Look - Alike”)**	**Health Maintenance Organization – HMO**
	In-Network	**Out-of-Network**	**In-Network**	**In-Network Only**
Hospital Services				
Inpatient Admit	15% of negotiated fees Subject to deductible	30% of U&C Subject to deductible	$400 per admission	$500 per admission
Ambulance			$75 copay	$75 copay
Hospice (Inpatient)			No copay	No copay
Skilled Nursing Facility			No copay Limit of 60 days/CY	No copay Benefit period begins 1st day of hospitalization or skilled nursing facility confinement; new benefit period begins with 60-day lapse between confinements
Other Benefits				
Durable Medical Equipment/External Prosthetic Appliances	15% of negotiated fees Subject to deductible Pre-authorization required for over $1000 purchased or cumulative rental value	30% of U&C Subject to deductible Pre-authorization required for over $1000 purchased or cumulative rental value	No copay $200 annual deductible for external prosthetic appliances Benefit is unlimited	No copay
Prescription Drugs				
Retail				
• Generic	20% of retail network price with a $6 minimum and $12 maximum Up to 30-day supply	50% retail network price less applicable minimum copay Up to 30-day supply	20% of retail network price with a $6 minimum and $12 maximum Up to 30-day supply	$10 copay Up to 30-day supply
• Brand-Name	Preferred—30% of retail network price with a $25 minimum and $40 maximum Up to 30-day supply	50% retail network price less applicable minimum copay Up to 30-day supply	Preferred—30% of retail network price with a $25 minimum and $40 maximum Up to 30-day supply	$30 copay Up to 30-day supply
	Non Preferred—40% of retail network price with a $40 minimum and $60 maximum Up to 30-day supply	50% retail network price less applicable minimum copay Up to 30-day supply	Non Preferred—40% of retail network price with a $40 minimum and $60 maximum Up to 30-day supply	N/A
Mail Order				
• Generic	20% of mail order price with a $12 minimum and a $24 maximum Up to 90-day supply	N/A	20% of mail order price with a $12 minimum and a $24 maximum Up to 90-day supply	$20 copay Up to 100-day supply
• Brand-Name	Preferred—30% of mail order price with a $50 minimum and a $80 maximum Up to 90-day supply	N/A	Preferred—30% of mail order price with a $50 minimum and a $80 maximum Up to 90-day supply	$60 copay Up to 100-day supply
	Non Preferred—40% of mail order price with a $80 minimum and a $120 maximum Up to 90-day supply	N/A	Non Preferred—40% of mail order price with a $80 minimum and a $120 maximum Up to 90-day supply	N/A
Specialty Drugs	Refer to the Retiree Open Enrollment book for more information	N/A	Refer to the Retiree Open Enrollment book for more information	N/A
Behavioral Health				
Mental Health				
• Inpatient	15% of negotiated fees Subject to deductible Combined maximum of 90 days/calendar year for In-network and Out-of-network charges for Inpatient Mental Health and Inpatient Substance Abuse	50% of U&C Subject to deductible/Does not apply to out of pocket maximum Combined maximum of 90 days/calendar year for In-network and Out-of-network charges for Inpatient Mental Health and Inpatient Substance Abuse	$400 per admission Maximum of 45 days/CY	$500 copay Maximum of 45 days/CY
• Outpatient	15% of negotiated fees Subject to deductible Unlimited visits	50% of U&C Subject to deductible/Does not apply to out of pocket maximum Unlimited visits	$30 copay Maximum of 30 visits/CY	$20 copay 20 individual/group therapy visits/CY with 20 additional group therapy visits if criteria met
Substance Abuse				
• Inpatient	15% of negotiated fees Subject to deductible Combined maximum of 90 days/calendar year for In-network and Out-of-network charges for Inpatient Mental Health and Inpatient Substance Abuse	50% of U&C Subject to deductible/Does not apply to out of pocket maximum Combined maximum of 90 days/calendar year for In-network and Out-of-network charges for Inpatient Mental Health and Inpatient Substance Abuse	$400 per admission Maximum of 15 days/CY	$500 copay
• Outpatient	15% of negotiated fees Subject to deductible Unlimited visits	50% of U&C Subject to deductible/Does not apply to out of pocket maximum Unlimited visits	$30 copay Maximum of 30 visits/CY	$20 copay Unlimited visits

This information is a condensed summary and does not replace or modify the Summary Plan Description (SPD) or Evidence of Coverage (EOC) for the plans. If there is any discrepancy in the information on this grid, the SPD or the EOC, the SPD or EOC supercedes. Last updated 9/08